

FOCUS ON

Foundations of Health Promotion



Published: August 2023

Introduction

Health promotion has a long history in Canada and internationally. Today, health promotion is recognized as a core function of public health.¹ In Ontario, it is practiced in public health units, community health centres and Aboriginal Health Access Centres, family health teams, hospitals, non-governmental organizations and charities at the community and provincial level. For health promoters and those working alongside health promoters, understanding the origins and evolution of health promotion can inform practice, by bringing context and understanding to its origins, and by exploring what health promotion means in an evolving modern world. With the myriad of challenges our societies and health systems face today, health promotion is uniquely poised to prevent disease and keep people well, thereby preserving our overburdened health care systems.²

This Focus On provides an overview of the foundational concepts integral to health promotion and discusses the development, effectiveness and implementation of the Ottawa Charter for Health Promotion. This resource was developed to support practitioners new to health promotion and for those who would like to review these foundational concepts.

Methods

This resource is part of a larger project to redevelop Public Health Ontario's (PHO's) health promotion materials and products. This has included several literature searches conducted to identify and describe: the evolution and development of health promotion, including the development, criticisms, implementation and effectiveness of the Ottawa Charter; the current state of health promotion; the values that ground health promotion; ethical considerations for health promotion; and future trends for the field of health promotion. Search strategies included: published literature databases (MEDLINE, CINAHL, PsycINFO, Embase, and Scopus) and grey literature, with search strategies developed by PHO Library Services; and hand searching of the last three years of four health promotion journals (Health Promotion International, American Journal of Health Promotion, Health Promotion Practice, Global Health Promotion) and the Canadian Journal of Public Health. Detailed search strategies are available upon request from PHO. Results from each search were collated and analyzed for content relevant to this Focus On.

Identified papers were screened by two authors using inclusion and exclusion criteria specific to the research question for each search. Additional resources contributed by key informants, and consultations with PHO's Health Promotion Foundations Course Advisory Committee (HPFC-AC), complemented the search strategies. Data extraction was completed by two authors using extraction categories specific to each research question. Data extraction tables were verified by the lead author. Results from each search were collated and analyzed for any content relevant for this Focus On.

This particular resource draws on the portions of the research conducted around the evolution of health promotion and the Ottawa Charter. This includes an analysis of gaps in theory vs implementation in literature, described as "push/pulls" by the HPFC-AC. These "push/pulls" describe the differences between how health promotion was initially conceptualized versus how it is implemented in practice. To identify these, we looked for text in the included papers that described the origins/intent of the Charter and/or health promotion, followed by a qualifier (for example, "however" or "despite") followed by an example of actual implementation. The category of "push/pulls" was included in the data extraction template for all conducted searches. During full text screening both authors extracted "push/pulls" and all extracted data were reviewed by the lead author. The lead author then reviewed included papers to ensure that all "push/pulls" were extracted, including their surrounding context. Thematic analysis was done following the six steps outlined by Braun & Clark 2006: familiarize oneself with the data; generate initial codes; search for themes; review themes; define and name themes; produce the report.³ Categories were developed to describe the extracted "push/pulls" and original papers were revisited to verify the context of the extracted text. Categories were compared to ensure that they were distinct.

This resource begins with a descriptive summary of the beginnings of health promotion and the development of the Ottawa Charter followed by evidence of its effectiveness and "push/pulls" around theory and implementation.

Results

The Emergence of Health Promotion

Historically, health education was the primary method used to promote health.^{4,5} In the 1950s through the 1970s, a number of education campaigns were implemented, aimed at changing the behaviour of individuals by increasing their knowledge and changing their perception of risk related to certain behaviours.⁵ Unfortunately, these campaigns did not have the desired effect:^{4,6} individuals, even when better informed, did not make the expected behaviour changes.^{5,7}

In 1974, then Minister of National Health and Welfare Marc Lalonde, released a report titled *A New Perspective on the Health of Canadians*.⁸ Commonly referred to as the Lalonde Report, it was the first document produced by a government of a major developed country that advocated for the investment of resources beyond health services and health care to improve the health of the population and reduce health care costs.⁵ The report introduced the Health Field Model, which recognized four factors that determine health status: health care, human biology, environment, and lifestyle. The report also introduced the term “health promotion” as a key strategy for improving health.^{5,8,9}

A flurry of activity in Ontario and Canada followed the release of the Lalonde report. A Health Promotion Branch was created within the Ontario health ministry in 1975.¹⁰ Federally, the Health Promotion Directorate, housed within the Department of National Health and Welfare, was established in 1978.⁹ The directorate focused on the lifestyle factor of the Health Field Model.⁵ Internationally, several Western industrialized countries also produced versions of the Lalonde report, customized to their local contexts, and encouraging investments in sectors beyond health care in order to improve population health and reduce health care costs. In the 1980s many Ontario municipal health departments began to develop approaches that emphasized structural determinants, community development, and advocacy.⁹

In 1984, the Toronto Board of Health, the Canadian Public Health Association (CPHA) and Health & Welfare Canada jointly sponsored an international conference called *Beyond Health Care*. This conference brought Canada onto the world stage and to the attention of the World Health Organization (WHO) as leaders in health promotion.⁹

The Ottawa Charter for Health Promotion

In 1986, the first Global Health Promotion Conference was held in Ottawa by the WHO, CPHA, and Health and Welfare Canada.¹¹ Federal Minister for Health and Welfare, Jake Epp, presented the government’s perspective on health promotion, *Achieving Health For All: A framework for health promotion*.¹² The report, commonly called the Epp Report, emphasized links between health and economic status and stated that “health promotion implies a commitment to dealing with the challenges of reducing inequities, extending the scope of prevention, and helping people to cope with their circumstances.”¹²

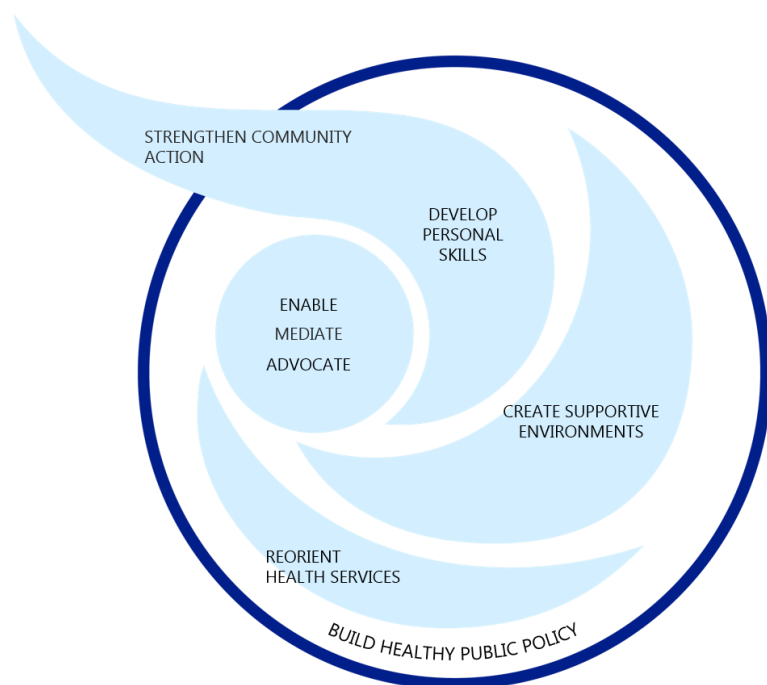
The Ottawa Charter (the Charter) was drafted by the WHO, based on background papers prepared for the conference, and ratified by conference attendees on the final day of the conference. The Charter identified how to “take action to achieve Health for All by 2000 (and beyond)”.¹³ The Charter was seen as a consolidation of a “new public health movement”,^{14,15} moving the discipline away from a medical focus on personal health risks and lifestyle choices.¹⁶ The Charter provided the fundamental strategies and approaches that practitioners considered vital for major progress in health promotion:¹⁴ a framework for health promotion practice that is still used today.^{16,17}

Health promotion continued to develop through subsequent WHO Global Health Promotion Conferences,⁴ (see [Appendix A](#)) as well as in research and practice. Additional declarations by organizations such as the European Public Health Association,¹⁷ have added to the content in the Charter. Therefore, descriptions of the Charter presented here include both the original 1986 Charter and more recent sources. Health promotion is defined as:

“The process of enabling people to increase control over, and to improve their health,¹³ and its determinants.¹⁸ To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health, by this definition is regarded as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. By extension, health promotion becomes not just the responsibility of the health sector, but goes beyond healthy lifestyle choices to overall well-being.¹³”

The Charter recognized eight pre-requisites for health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.¹³ These pre-requisites, more recently described as the social determinants of health,¹⁹ describe what is necessary in order reach a state of health.

Figure 1. The Ottawa Charter for Health Promotion



Adapted from: World Health Organization (WHO); Health and Welfare Canada; Canadian Public Health Association. Ottawa charter for health promotion: an international conference on health promotion [Internet]. Ottawa, ON: World Health Organization; 1986 [cited 2023 Mar 01]. Available from: <https://www.canada.ca/content/dam/phac-aspc/documents/services/health-promotion/population-health/ottawa-charter-health-promotion-international-conference-on-health-promotion/charter.pdf>. License: [CC BY-NC-SA 3.0 IGO](#). This adaptation was not created by WHO. WHO is not responsible for the content or accuracy of this adaptation. The original edition shall be the binding and authentic edition.

The Charter named three Core Health Promotion Functions: to **advocate** for conditions favourable to health; to ensure equal opportunities and resources to **enable** all people to achieve their fullest health potential; and to **mediate** between differing interests in society for the pursuit of health.¹³ To implement these core functions, five Action Areas extend health promotion strategies beyond information and education to collective and multi-strategy responses.²⁰ These action areas are designed to interconnect:^{7,21} they are interactive and interdependent processes that contribute to and reinforce one another.²⁰ This interdependence implies that health promotion responses should incorporate most, if not all, of the action areas.^{20,22}

Table 1. The Five Action Areas of the Ottawa Charter

Action Area	Description	Actions
Build healthy public policy	<p>Healthy public policies aim to improve the circumstances in which people are born, grow, work, and age.²⁰ Healthy public policies create the sorts of supportive environment that enable people to live healthy lives by putting health on the policy agenda in all sectors and at all levels.²³</p> <p>Building healthy public policies involves advocating for, establishing, and/or implementing explicit actions by governments at the local, provincial/territorial, national, and international levels.²⁰</p>	<p>Actions include legislation, regulatory and fiscal measures, as well as operating procedures that may be required for these actions to be implemented.²⁰</p> <p>Healthy public policies can be developed and implemented in and across a variety of sectors, including (but not limited to) health, housing, education, employment, transportation, taxation, child health and the environment.²⁰</p>
Create supportive environments	<p>Creating supportive environments involves developing physical and social environments in ways that support health and protect against physical hazards and socially/psychologically damaging practices.²⁰ This action area includes the impacts of climate change on human health.²⁴</p> <p>Creating supportive environments acknowledges the interconnectedness between people and their environment, and recognizes that people, communities and the environment need to be cared for and protected.²¹</p>	<p>Actions include changes to physical environments (natural and built); social environments; psycho-social, economic and cultural environments, organizational change; changes in infrastructure, programs, and services.²⁰</p> <p>Individuals, community groups, organizations and governments can take action at the structural, social, and personal levels.²⁰</p>

Action Area	Description	Actions
Strengthen community action	Strengthening community action is defined as expanding the resources and capacities of communities to make decisions and to take collective action to increase their control over the determinants of their health. ²⁰	Actions include developing networks and programs, advocating for service or program improvements, advocating for organizational change, and advocating for changes to public policies. ²⁰
Develop personal skills	Developing personal skills means enabling individuals to understand and critically use health information, then developing skills to improve their health. ²⁰ It goes beyond the provision of information; it is about developing a set of empowering personal skills that enable communities to engage in a range of actions. ²⁴	Actions include promoting health literacy, ¹⁷ providing opportunities for participants to interact with and critically discuss health information, ²⁰ and providing opportunities to develop and practice skills. ²⁰
Re-orient health services	Re-orienting health services is defined as developing the capacity of health systems and programs to achieve improved population health and greater health equity, and enabling all people- whether sick or well- to move along the health-illness continuum towards health. Actions can take place at structural, organizational and service levels. ²⁰	Actions include increasing infrastructure and resources for health promotion programming, extending health promotion attention to new issues and strategies, adding health promotion and early intervention components to clinical services, and adapting clinical services. ²⁰

The Charter also introduced the concept of the settings approach to health promotion,²⁵ where health promotion responses are implemented in settings such as cities, islands, municipalities, local communities, markets, schools, workplaces and health care facilities.²⁶ The settings approach is grounded in the recognition that health is created and lived by people within the settings of their everyday life. Healthy Settings key principles include community participation, partnership, empowerment and equity.²⁵ Health Promoting Schools,²⁷ Healthy Cities,²⁸ and Health Promoting Hospitals,²⁹ are examples of settings-based health promotion responses.

The Charter in Context

There are criticisms of the Charter. Attendance at the first Global Health Promotion Conference was by invitation only, included 38 wealthy industrialized countries, and focused exclusively on the needs of those countries.^{4,9,24} For example, the concept of “healthy public policy” came from an analysis of the impact of national public policies in democratic, wealthy industrialized countries with social welfare systems.²⁴ It was not clear at the time if healthy public policy would be transferable to countries of different circumstances.³⁰ Indigenous peoples and developing countries were excluded from the conference, as well as from the background papers developed for the conference which informed the development of the Charter itself.⁹ For these reasons, the Charter is viewed as a Euro-centric and colonial document.³¹

EFFECTIVENESS OF THE OTTAWA CHARTER

Few systematic reviews on the effectiveness of the Charter were found using our search strategy: two were conducted in the mid-2000s in preparation for the 2005 Bangkok Global Conference. A systematic review by Wise and Nutbeam,⁴ assessed the evidence around re-orienting health services. A review by Jackson et al.³² examined the remaining four action areas. Wise and Nutbeam found little evidence that re-orienting health services has occurred systematically, therefore insufficient evidence of effectiveness was found.⁴ Similarly in the review by Jackson et al, the effectiveness of strengthening community action could not be determined.³² The authors of both papers commented on the difficulty of examining action areas in isolation from one another, given that they were designed to interconnect.^{20,32} Even with lack of evidence regarding two of the action areas, health promotion was found to have been effective at preventing and addressing a wide variety of chronic diseases and their associated risk factors, as well as addressing the social determinants of health. Interventions using a combination of health promotion strategies and actions were found to be most effective as well as cost-effective. The authors present six key lessons drawn from the common findings of the studies included in the systematic review:

1. Investment in building healthy public policy is a key strategy;
2. Supportive environments need to be created at the individual, social and structural levels;
3. Effectiveness of strengthening community action is unclear and more research and evidence are required;
4. Development of personal skills must be combined with other strategies in order to be effective;
5. Interventions employing multiple strategies and actions at multiple levels are most effective;
6. Certain actions are central to health promotions' effectiveness. These include: intersectoral action and inter-organizational partnerships at all levels; community engagement and participation in planning and decision making; creating healthy settings (particularly focusing on schools, communities, workplaces and municipalities); political commitment; funding and infrastructure; and awareness of the socio-environmental context.³²

THEORY-TO-IMPLEMENTATION GAP

Health promotion has influenced many aspects of health practice,¹⁷ however in many ways it has not been fully implemented as envisioned in the Charter.^{20,19} There are often gaps between theory and implementation: in other words, there is a gap between how health promotion is described and what the literature may tell us regarding effectiveness, and how health promotion is implemented in practice. The HPFC-AC describe these instances as “push/pulls” or tensions between theory and practice.³³ The literature described several of these theory-to-implementation gaps. They have been categorized and described separately, though they are interrelated.

- **Health behaviourism:** This term describes health promotion actions directed at individual behaviour change, primarily through health education, versus actions that are rooted in the socio-ecological model of health conceptualized by health promotion.³⁴ An example of health behaviourism is the distribution of information, perhaps via a website or weekly course, about health and lifestyle risks or benefits associated with different behaviour, on the assumption that this will motivate individuals to modify their behaviour.⁶ A focus on behaviour change puts the onus on the individual engaging in the behaviour,³⁵ neglecting the broader social and political drivers of health behaviours.³⁶ For example, we know that chronic diseases and certain health behaviours (e.g., smoking commercial tobacco products) are more prevalent among communities experiencing social and economic disadvantages.⁶

- **Lifestyle drift:**^{9,17,37-39} Despite recognition of the need for action on the upstream social determinants of health, there is a tendency for health promotion actions to “drift downstream” and focus largely on individual lifestyle factors.³⁷ For example, a report might identify that the social determinants of health significantly impact cancer control, however the resulting health promotion response focuses on generating individual lifestyle changes.⁶ As with health behaviourism, a key criticism of this “lifestyle approach” is its focus on the individual’s responsibility to make healthier choices in order to avoid health problems.¹⁷ This focus does not recognize that choices are largely shaped by social, economic, commercial and political determinants, and therefore the resulting health promotion actions do not address or change the underlying conditions that result in ill health.^{15,32}
- **Individualism:** This term describes the focus on individual responsibility, versus a recognition of a social model of health⁴⁰ that is grounded in the social-political drivers of health behaviours; described as the “causes of the causes” or determinants of behaviour.⁴¹⁻⁴³ The Ottawa Charter “steered” health promotion away from the individual-focused health education models that dominated the field, towards a socio-ecological version rooted in the structural determinants of health.³⁸ Health promotion recognizes that personal lifestyles are not freely determined by individual choice, and that those choices are constrained by social and cultural structures that dictate and limit behaviour.⁹
- **Prioritization of health care:** This describes the prioritization of the treatment and prevention of disease versus the promotion of health.³⁹ This “default lever of improving access to clinical care”⁴⁴ comes from the biomedical model which views health as a dichotomy between health and disease, rather than the definition of health as a “resource for life” as described in the Charter.³⁰
- **Single issue responses:** This describes the selection of single issue responses and programs, versus the multi-level strategic approaches and collective action incorporating multiple action areas described in the Charter.^{20,21} As previously discussed, the action areas in the Charter are designed to interconnect,²² and reinforce one another.²¹ In particular, development of personal skills must be combined with other action areas in the Charter in order to be effective. Comprehensive tobacco control provides an example: actions included policy measures such as banning advertising, placing warnings on cigarette packages and taxation measures; supportive environments were created through smoking bans and smoke-free areas, and cessation services aimed to build personal skills.³²

Discussion

The world has significantly changed since the Charter was written in 1986: there have been substantial social and economic changes, trade has been globalized, and more people live in cities than ever before.²⁴ Life expectancy has risen, but there is a growing prevalence of chronic diseases, injuries and violence.⁹ The internet emerged and now dominates as a source of knowledge, with mobile and digital technologies increasing access to both information and misinformation.^{45,46} Planetary health and the urgency of climate change are widely recognized as the most critical issues facing the planet today.^{39,47-49} The health promotion workforce has expanded in size, diversity, and competencies, with undergraduate and graduate programs in health promotion multiplying rapidly.⁹

Given this, it is valid to wonder if a document created in 1986 should continue to be the “guiding document” for the field of health promotion. In examining both literature and current practice, the Charter is still viewed as that guiding document: Global Health Promotion Conferences and their resulting statements and charters (please see [Appendix A](#)) continue to build on the legacy of the Charter and broaden the focus on and involvement of non-OECD countries and Indigenous peoples. The Charter continues to be referred to in the recently published literature that we have examined for this Focus On. As previously discussed, the Charter is viewed as a Euro-centric and colonial document. This criticism often extends beyond the Charter to health promotion itself. Due to its association with the WHO in general and WHO EURO in particular, health promotion has been seen as a product of high-income countries.¹⁷ Since the first Global Health Promotion Conference in Ottawa in 1986, the WHO has made efforts to broaden the inclusion of the global community. The 1988 conference in Adelaide on the topic of healthy public policy indicated that healthy public policy should recognize the “unique culture of Indigenous peoples, including acknowledging their inherent right to be self-determining and the Indigenous knowledges they hold, as a fundamental means through which to create the conditions for equal access to health.”²³ In 1997, a non-OECD country, Indonesia, hosted a Global Health Promotion Conference for the first time.²⁶ The following year the World Health Assembly recognized the vision of the Ottawa Charter and established a health promotion mandate for the WHO.¹⁷ The 2005 Bangkok conference included representatives from all regions and confirmed the relevance of health promotion for low-and-middle-income countries.¹⁷ The 2016 conference, held in Shanghai, focussed on the role of health promotion in achieving the Sustainable Development Goals.⁵⁰

Health promotion is not in the sole purview of the WHO. The International Union of Health Promotion and Education (IUHPE) holds World Conferences on Health Promotion every three years (beginning in 1951, with the origins of the organization in health education).⁵¹ The 23rd World Conference was held in New Zealand and resulted in two statements. The *Waiora Indigenous Peoples’ Statement for Planetary Health and Sustainable Development* was developed by Indigenous participants at the conference and calls on the health promotion community to make space for and privilege Indigenous peoples’ voices and Indigenous knowledges in promoting planetary health and sustainable development. The *Rotorua Statement* was developed by all conference attendees and calls on the global community to act to promote planetary health and sustainable development. The most recent conference, held in Tiohtià:ke, now known as Montreal in 2022, built on the Waiora and Rotorua statements. The *Tiohtià:ke Statement* recognizes the impacts of colonialism on Indigenous peoples and provides four action areas to privilege Indigenous peoples’ voices and knowledge and put well-being, the health of the planet, and equity into all policies.⁵² The hand-searching of four health promotion journals and the CPHA journal found several papers relating to Indigenous health promotion, anti/post-colonialism, Black health promotion and anti-racism, demonstrating the importance of these conversations in the current health promotion discourse.

Thus, while the Ottawa Charter itself remains unchanged, the field of health promotion has continued to progress in research, practice, and subsequent Global Health Promotion Conferences, and the work of national and international health promotion organizations such as IUHPE. Health promotion cannot be assessed as solely the product of the Ottawa Charter, and the Ottawa Charter must be considered and applied in a much broader context than the one in which it was created.

Two key challenges noted from reviewing the relevant literature for this Focus On were: a lack of recent, high-quality evidence regarding the effectiveness of health promotion, and relatedly, the gaps between health promotion theory and how health promotion is implemented. We have described the latter as “push/pulls” or tensions between research and practice. It is difficult to determine the effectiveness of a framework and practice which is not implemented as designed. There remains a tendency for health promotion actions to focus on lifestyle factors, health behaviours and individual approaches, despite the Charter’s vision of health beyond the biomedical model, which views health as the absence of disease,^{17,30} and the behavioural model, which views health as the product of lifestyle choices.¹⁵ Reasons for this are complex, and vary within and between countries. A 2014 analysis by Baum and Fisher discusses the preoccupation with behavioural health promotion strategies despite their known ineffectiveness in improving population health measures and reducing health inequities.⁶ The authors suggest a number of reasons for this drift towards behavioural health promotion: a dominant public discourse that poor health is an outcome of poor choices, leading to the view that lifestyle changes will prevent poor health; ideological factors such as neoliberalism or the belief that individuals economic circumstances are a result of their own choices; the challenges of implementing regulations (e.g., lowering sodium in foods) versus the simplicity of making individuals responsible for their choices.⁶

Health promotion’s vision is socio-ecological.⁹ It aims to transform the social conditions that shape health and the distribution of health.¹⁷ There is a recognition that in creating the conditions for equitable access to health, particular attention must be paid to unique contexts and histories.²³ Health promotion recognizes that peoples’ choices result from their circumstances, and therefore addresses the structures that support or constrain health.¹⁵ Health promotion responds to the need to take action on the social determinants of health and empowers communities to be at the centre of this action.⁹ This position is echoed in modern public health practice in Ontario, through the explicit grounding of action on the social determinants of health in the Ontario Public Health Standards.⁵³

At an implementation level, Green & Kreuter (2005) describe health promotion as “any planned combination of educational, political, regulatory and organizational supports for actions and conditions of living conducive to the health of individuals and communities.”⁵⁴ This speaks to the broadness of health promotion: from standardized top-down national programs to unique grass-roots initiatives; macro-level and local-level change reorienting health systems; local-level change to develop personal skills; and multi-sectoral initiatives aimed at strengthening community action.⁵⁵

Health promotion is a multidisciplinary, multi-strategy endeavor, with health promoters coming from variety of professional backgrounds, such as nursing, social work, dietetics, family and community health.^{43,56} In Ontario, health promoters work in a variety of settings: including public health units, community health centres and Aboriginal Health Access Centres, family health teams, hospitals, non-governmental organizations, charities at the community and provincial level. While health promoters come from different backgrounds, with varying degrees of formal training in health promotion, there is a specific body of skills, knowledge and expertise that is distinctive to health promotion.⁴³ The Pan-Canadian Health Promoter Core Competencies were developed by Health Promotion Canada in 2015, to create a common understanding of the role and best use of health promoter positions.⁵⁷ Eight competencies describe the expected capacities of health promoters: applying health promotion theories; conducting situational assessments, planning, implementing and evaluating health promotion action; advocacy and policy development; community mobilization and community capacity building; partnership and collaboration;

health community; working with diverse communities; building organizational capacity.⁵⁷ In this way, as described by a member of the HPFC-AC, health promoters are the “Swiss army knife” of the health sector, with a variety of applicable and transferable skills.⁵⁸

Limitations and Strengths

This Focus On leveraged several search strategies conducted to inform the redevelopment of PHO’s health promotion materials and products. While four individual research questions guided the literature searches, additional questions, such as the theory to implementation gaps or “push/pulls” were applied to the results vs conducting separate searches. Therefore, we likely did not find all “push/pulls” impacting health promotion practice today.

The literature searches were conducted in English. Two French texts that appeared in the English search results were included, however searches in languages other than English were not conducted. Additionally, while the HPFC-AC was involved in the development of the online health promotion course, they are not representative of the entire field of health promotion or the entire province of Ontario. Therefore, the strategies used for this product may be replicating the same exclusionary practices (relating to non-Western countries and Indigenous exclusion) in which the Charter was developed.

Conclusion

The vision of health promotion comes from a vision of how the world could be if it was based on an understanding of the determinants of health.¹¹ At a practical level, health promotion is variety of strategies and projects,⁵⁹ that we develop, implement and sustain in order to build healthy public policy, develop personal skills, create supportive environments, strengthen community action, and reorient health services.⁷ In this way, health promotion is, as described by Stacy Carter, both “a normative ideal and a practice”: a vision to be achieved along with a practical series of actions in order to accomplish that vision.

“As normative ideal, health promotion is a vision of how society should be arranged, a set of political and moral commitments. These commitments include: to health as a resource for living rather than an end in itself, health as the product of social, environmental and economic living conditions, egalitarianism, and working in collaboration with citizens. It is a commitment to a particular idea of the good society, and of the relationship between the state and its citizens.”⁵⁹

A recent study in the American Journal of Public Health reported that, with the shift in public health towards population health based initiatives, skills are needed in community engagement, cross-sectoral partnerships, systems thinking, policy development, and capacity to promote health equity. These skills are amongst the “Swiss army knife” of competencies possessed by health promoters, making the health promotion workforce part of the solution to meeting today’s public health system challenges.

Initially developed almost forty years ago, the Ottawa Charter for Health Promotion remains a guidepost for the field of health promotion. The content presented here can provide additional context to aid practitioners in adopting the Charter in a way that is current and responsive. For, just as the world is evolving, the practice of health promotion must evolve in order to remain relevant, credible, and effective.

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Appendix A: Global Health Promotion Conferences

Global Health Promotion Conference	Conference Title	Location and year	Conference Topic	Resulting Document
First	The Move Towards a New Public Health	Ottawa, 1986	Achieving health for all by the year 2000, and beyond	Ottawa Charter for Health Promotion
Second	Healthy Public Policy	Adelaide, 1988	Formulating and implementing healthy public policy	Adelaide Recommendations on Healthy Public Policy
Third	Supportive Environments for Health	Sweden, 1991	Making the environment - the physical environment, the social and economic environment, and the political environment - supportive to health rather than damaging to it.	Sundsvall Statement on Supportive Environments for Health
Fourth	New Players for a New Era - Leading Health Promotion into the 21st Century	Jakarta, 1997	Identifying the directions and strategies that must be adopted to address the challenges of promoting health in the 21st century	Jakarta Declaration on Leading Health Promotion into the 21st Century
Fifth	Health Promotion: Bridging the Equity Gap	Mexico City, 2000	Bridging the equity gap both within and between countries	Ministerial Statement for the Promotion of Health
Sixth	Policy and Partnership for Action: Addressing the Determinants of Health	Bangkok, 2005	Addressing the determinants of health in a globalized world through health promotion	Bangkok Charter for Health Promotion in a Globalized World
Seventh	Promoting Health and Development: Closing the Implementation Gap	Nairobi, 2009	Examining the gaps and the role of health promotion in closing them	Nairobi Call to Action
Eight	Health in All Policies	Helsinki, 2013	Implementing Health in All Policies	Helsinki Statement on Health in All Policies

Global Health Promotion Conference	Conference Title	Location and year	Conference Topic	Resulting Document
Ninth	<u>Promoting health in the Sustainable Development Goals: Health for all and all for health</u>	Shanghai, 2016	Highlighting the critical links between promoting health and the 2030 Agenda for Sustainable Development.	<u>Promoting health in the Sustainable Development Goals</u>
Tenth	<u>Health promotion for well-being, equity and sustainable development</u>	Geneva and online, 2021	How health promotion can contribute to creating flourishing and well-being societies	<u>Geneva Charter for Wellbeing</u>

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Citation

Ontario Agency for Health Protection and Promotion (Public Health Ontario). Focus on: foundations of health promotion. Toronto, ON: King's Printer for Ontario; 2023.

ISBN 978-1-4868-7279-4

Disclaimer

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