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HEALTH PROMOTION: ACHIEVEMENTS AND LESSONS LEARNED FROM OTTAWA TO BANGKOK

The Ottawa Charter (1986) was the product of an in-depth critical analysis of public health, recognizing social and environmental factors, including lifestyles, as basic elements in health promotion. It has significantly influenced public health theory in the Region, contributing to changes in the biological paradigm of health and laying the foundations for a deeper understanding of the social determinants of health. The Charter stresses the intersectoral nature of health promotion, as well as the importance of public policies and community empowerment in this process. Over the past 20 years, the Ottawa Charter has served as a policy guide and inspiration for many governments, international agencies, universities, and sectors, as well as civil society, in their objective to improve health conditions and promote equity.

Numerous health promotion activities have been carried out in the settings where people live, study, and work, the most recognized examples of the application of the Ottawa Charter's five strategic actions being: the establishment of healthy public policies, developed more fully in the Adelaide Statement (1988); the creation of healthy spaces, expanded on in the Sundsvall Statement (1991); citizen participation in public health and primary care activities, buttressed with the Charter of Bogotá; personal skills to improve social communication and education in health, further developed in the Caribbean Charter; and the reorientation of health services, elaborated on in the Jakarta and Mexico Statements.

This document reviews the lessons learned from the Charters and Statements from Ottawa to Bangkok, using examples from the Region of the Americas. It also highlights the challenges to strengthening health promotion as an essential and strategic public health function, positioning it in a globalized world.

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Introduction

1. In 2005, to mark 20 years since the adoption of the Ottawa Charter (1986), the Member States requested an evaluation of the evolution, achievements, and lessons learned from the strengthening of health promotion in the Region, from Ottawa to the last conference on health promotion in Bangkok in 2005. The review in this document is based primarily on information furnished by the countries through two surveys on the map of institutional capacities in health promotion, conducted in 2002 and 2005, and the information gathered jointly with PAHO/WHO at meetings and events in which PAHO participated. Canada and Chile also contributed to the initial draft prepared in late 2005.

Regional History and Context

2. Since the 1970s, with advances in health sector decentralization and primary health care (PHC), new currents of thought in public health traced the parameters for the discussion of health problems and social processes. These produced the public policies that determine health and disease processes[1]. In different ways and with varying intensity, the new social approach to health influenced academic theory and some of the health policies and programs of certain countries in the Region. In Brazil this theory took materialized concretely in health sector reform processes that fostered social participation, promoting equity in access to services and considering health the result of certain conditions--i.e., nutrition, housing, education, income, environment, work, transportation, employment, and freedom. In the Brazilian Constitution, guaranteeing the right to health is a State obligation, and health is the product of decent living conditions and universal, equal access to health promotion, protection, and recovery actions and services. Other countries in the Region, such as Costa Rica, Chile, and Cuba, have implemented comprehensive care models that have had a positive impact on the health of the population. The Alma-Ata conference and the guidelines for primary health care (PHC) also had a great influence and impact, leading to a more integrated approach to public health interventions. (1)

3. Thus, the Ottawa Charter and the health promotion movement encountered a dual context in the Region.[2] On the one hand, conceptual development of public health theory that comes close to its new public health model, and on the other hand, a social development context in the countries marked by profound inequalities. The Charter of Bogotá (1992), the product of the first regional event on health promotion, emphasizes equity and violence and is oriented more toward intersectoral management of health with

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[1] The historic contributions of Villerme, Virchow, Winslow, Sigerist, the Black Report, Foucault, Berlinguer, Lalonde, Terris, Laurell, and other authors nourished this new approach to public health.

[2] ("*…this concept envisages that the field of health can be broken up into four broad elements: human biology, environment, lifestyle, and health care organization …*") in *Health Promotion: An Anthology*; PAHO, Scientific Publication No. 557; 1996; 3-5.

health sector leadership. This latter lost legitimacy with the sector's deterioration as a result of health reforms. The incorporation of health promotion was initially based on experiences and models taken from the developed countries for application to a situation characterized by poverty and inequality. This disjoint with the reality of the health systems was further exacerbated in the 1990s in countries undergoing structural changes in their health services.

4. A historical evaluation of health promotion reveals that the Ottawa Charter buttressed the primary health care model of Alma-Ata, as well as Latina America's theories of social determination in the 1980s. It also had a positive affect on health policies and programs, public policies, and community action (2). The Ottawa Charter reaffirmed the concept of health as well-being, which is central to sustainable development. Twenty years later, its principles and areas of action, further developed with the contributions of the five subsequent global conferences and culminating in the Bangkok Charter of 2005, are still vibrant and valid for guiding public health efforts with other sectors and citizens to promote equity in health.

5. Today, the great challenges in health promotion in a globalized world require going beyond the traditional sectoral approach centered on primary care and health care systems to develop education and communication interventions that impact personal behaviors or lifestyles. This is precisely why it was the main issue addressed in the Mexico Statement[3], which called on governments to exercise active leadership to guarantee a commitment by all public and private sectors and civil society to the development of healthy public policies. Today, the Ottawa Charter's call to adopt a new public health paradigm that supports health promotion as a strategy to enable individuals and the community to exercise greater control over social determinants and their health status and improve their quality of life, is still relevant. Equally so is taking action in public health that increases people's health potential through an ecological approach, applying the principles of equity, justice, democracy, empowerment, and intersectoralism.

[3] The Mexico Ministerial Statement for the Promotion of Health (2000), calls for addressing the social determinants of health, strengthening mechanisms for intersectoral collaboration at all levels of society, and establishing public policies in all countries in the search for equity. It agrees to the development of national plans for health promotion with expertise from WHO and its regional offices.

Achievements and Lessons Learned

6. The Mexico Statement makes a commitment to position health promotion as a key priority on the political and development agenda, a commitment reaffirmed in the Bangkok Charter in 2005 and several WHO and PAHO resolutions. In compliance with the Mexico Statement and Resolution CD43.R11 (2001), a study has been conducted on progress in health promotion in the Region of the Americas. (3) The preliminary version of this study was presented at the Chile Forum in 2002, and capacity map, completed in 2005, was presented during the Bangkok conference. The countries have generally made progress in some areas of health promotion, but they still have a long way to go.[4] For example, although health promotion occupies a significant place in national public policy in 44% of the countries of the Region, less than half of them have a political or legal framework that supports it (4).

Developing Healthy Public Policies[5]

7. The countries of the Americas have taken different approaches in advocating for the development and implementation of healthy public policies--approaches that respond to their different social, political, and economic circumstances. In general, this field is still in its infancy, but with considerable a difference between Ottawa (1986) and Bangkok (2005). Brazil has consolidated its Unified Health System, including the participatory budget, and has taken steps to adapt and set up healthy public policy demonstration areas in municipios, with the support of the councils of municipal and state health secretariats. Argentina has engaged in a serious debate on the impact of the economy on its health determinants and in response, has bolstered its social policies. Chile has put a health promotion policy known as *Vida Chile* [Life Chile] in place with an intersectoral approach to improve social determinants. Canada, Peru, and Paraguay have implemented specific policies for health risks related to tobacco, alcohol, and road safety. Barbados has established social participation mechanisms for policy-making through public consultations at both the national and community level. In the United States, over 11,000 comments were received from the public for the development of the

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[4] Thirty countries presented progress reports in 2002 on health promotion. A total of 28 countries in the Region participated in the institutional capacity map for health promotion developed in 2005, corresponding to a 77% response level.

[5] The Adelaide Recommendations on Healthy Public Policy (Australia, 1988), Second International Conference on Health Promotion, recognize the challenge of moving toward a new public health paradigm that reaffirms social justice and equity as essential prerequisites for health. They reaffirm the five areas of health promotion identified in Ottawa. It delves more deeply into the first of them--building healthy public policy--as the linchpin for improving health determinants and includes the following examples of healthy public policy: women's health; food and nutrition; tobacco; alcohol; and the creation of sustainable environments.

Healthy People 2010 policy. Trinidad and Tobago adopted national agreements and policies to promote health.

Creating Supportive Environments for Health[6]

Healthy Municipios and Communities (5)

8. The creation of supportive environments for health has been one of the areas with the greatest progress, becoming widespread in the Region over the past 10 years. Initiatives are under way in 95% of the countries to create healthy environments. Moreover, 70% of the countries have a strategic plan at the municipal level to create healthy environments. This initiative is based on a political commitment by the mayors and other local authorities and active citizen participation in identifying urgent needs and adopting strategic plans to address them(6) --plans that should be developed intersectorally with full community participation (7). Monitoring, evaluation, and the development of evidence in this area are matter is a real challenge. Only 35% of the countries report that their initiatives to create healthy environments have been evaluated (8). Developing networks and partnerships has been key in the dissemination of information and sharing of experiences among municipios and countries. Some 75% of the countries have networks that engage in advocacy for health promotion. The regional network has been difficult to maintain. However, the national networks of Argentina, Chile, Costa Rica, Cuba, Mexico, Paraguay, and Peru have been successful.

Regional Health-Promoting Schools[(9)] *Initiative*

9. This Initiative promotes the development of knowledge, abilities, and skills in the school environment to minimize risky behaviors and encourage healthy lifestyles. According a 2001 survey, 53% indicated that this strategy was in place. Countries such as Canada, Chile, Colombia, El Salvador, and Mexico are implementing the Initiative at the national level. In El Salvador coverage began in 1996 with 124 schools in one Department, expanding by 1999 to 3,593 schools in 14 Departments. The information from this survey was used to development the Plan of Action 2003-2012 for the Regional Health-promoting Schools (HPS) Initiative; this plan was adopted by the HPS networks in their third annual meeting in Quito, Ecuador in 2002 (10). The participating countries are moving toward the development of procedural guidelines for the certification and accreditation of health-promoting schools. As for evaluation, 47% of the countries

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[6] The Sundsvall Statement on Health-promoting Schools (Sweden, 1991) issues a call for everyone to make a commitment to developing healthy settings in both the social and physical environment. The action proposal is grounded in two fundamental principles: equity and the strengthening of public action. The Statement calls on WHO and the United Nations Environmental Program to step up efforts and develop guidelines for managing elements harmful to health and the environment and procedural guidelines based on sustainable development.

reported having qualitative and process indicators. The Initiative has strengthened national and subregional HPS networks.

Healthy Housing

10. The Healthy Housing Initiative has helped promote and protect the health of the populations most vulnerable to housing risks and has contributed to integrated local development. Estimates put the housing shortage in Latin America and the Caribbean at approximately 23 and 28 million units, respectively. Poor housing conditions impact health, especially in the poorest and vulnerable populations, such as children, the disabled, and older adults, since they spend most of their time in their homes. The VIVSALUD Network has national networks in 12 countries, working with the United Nations Human Settlements Program (UN-HABITAT) and the Economic Commission for Latin America and the Caribbean (ECLAC) to distribute guidelines for national and local authorities on the main components of the healthy housing strategy. Advocacy efforts have been under way for regional implementation of Colombia's community program HEALTHY HOUSING so that my Family can Live, which has been used to train over 300 professional and technical personnel in bioclimatic architecture, sustainable construction, vector elimination, and healthy housing. The Canada Mortgage and Housing Corporation (CMHC) promotes the concept of healthy housing and publishes guides and pamphlets to make healthier homes of its housing.

Strengthening Community Action and Social Participation

11. Ninety percent of the countries report mechanisms and opportunities for active citizen and community participation. The most common mechanisms or forms of citizen participation are roundtables, forums, and public consultations, with citizens participating chiefly in the identification of health promotion needs. The past 20 years have witnessed an enormous growth in nongovernmental organizations (NGOs), which have taken on public health functions and become key players in the definition, approach to, monitoring, and evaluation of priorities. Canada has a national initiative for community participation in health (Voluntary Sector Initiative). Brazil, Chile, and Ecuador have made substantial progress in incorporating community and civil society participation into the health system.

Development of Personal Skills and Empowerment

12. Notwithstanding the development of new health education strategies, the progress in this area is not evident. Diseases in which personal attitudes exert the greatest influence now rank first in the burden of disease. Addictions, obesity, a sedentary lifestyle, poor nutrition, and family violence are some of the risk factors whose severity has increased. Few countries have taken steps to change behavioral trends--this, despite

the many health education programs and media campaigns. A sedentary lifestyle, obesity, violence, traffic injuries, addictions, and other risks are steadily on the rise, due in part to the persistence of top-down, unparticipatory linear approaches focused on a single factor. The medical model continues to prevail, overemphasizing a disease and risk approach and underemphasizing the influence of social conditions and determinants.

Reorienting the Health Services

13. Ninety percent of the countries report having some policy or initiative in the health services to promote health, beyond the prevention and treatment of disease. Several countries have developed and implemented comprehensive health care models, mainly at the subnational level. The life cycle approach has gradually been incorporated in the reorganization of basic service networks.

14. In Nicaragua, Costa Rica, Mexico's Federal District, and Bogotá, Colombia, comprehensive care models are being included in health and/or social development plans. Integrated health care is the guiding principle of Brazilian Health Sector Reform and is at the heart of the Family Health Strategy. Chile's Bridging Program and Peru's recently launched Together Program integrate primary health care services with other social services for families. FOROSALUD, a broad federation of civil society organizations in Peru, and the Congresses for Health and Life in Ecuador actively engage in advocacy to reorient the health services, promoting a comprehensive intersectoral approach.

15. These processes still face many challenges, ranging from a lack of resources to the profound operational fragmentation of the services into multiple disjointed, parallel, duplicate, overlapping, and uncoordinated subnetworks, within the context of the growing institutional and organizational segmentation of health systems in the Region.

Intersectoral Collaboration

16. Intersectoral consensus-building is indispensable to health promotion. Thirty-five percent of the countries in the Region have an intersectoral council or committee. The experiences of Canada, Argentina, Brazil, Costa Rica, Cuba, Mexico, Peru, the Healthy People 2010, *Vida Chile,* and other programs offer examples of committees, consortia, and other forms of collaboration and partnerships between social organizations and government agencies for the implementation of public policies and other strategic health promotion activities (11). Notwithstanding the efforts and progress made, intersectoral collaboration has faced numerous challenges, partly from bureaucratic structures and vertical programs in the countries and departments and partly from the educational structure, which emphasizes training by discipline, with little encouragement of an interdisciplinary approach. Another factor is the trouble the sectors have working together toward a common goal.

Evidence and Evaluation of the Extent of Health Promotion

17. Sixty percent of the countries in the Region have a surveillance system for health risk factors. Argentina, Brazil, Cuba, Mexico, and Peru have been adopting methodologies and implementing initiatives for evaluating health promotion. Canada, Chile, Colombia, Ecuador, the United States, Guatemala, and Venezuela are working to establish a surveillance system with social and epidemiological indicators for health determinants, as well as social and behavioral risk factors. Over the past five years, the Global Program on Health Promotion Effectiveness (IUHPE/WHO/CDC) has strongly encouraged capacity-building for the evaluation of health promotion initiatives and wider dissemination of good practices in health promotion.

Technical Cooperation of the International Organizations

18. PAHO has made a substantial contribution to health promotion, through both the development of agendas and presentations at the global conferences, especially the 5th Global Conference on Health Promotion in Mexico, 2000. Moreover, it has actively supported regional meetings on health promotion, such as those in Bogotá in 1992 and the Caribbean in 1993 and the Chile Forum in 2002. It has put the health promotion strategy on the Governing Bodies' agenda through Resolution CD37.R14 and the Regional Plan of Action for Health Promotion in the Americas CE113/15 (PAHO 1994), as well as Resolution CD43.R11 and the document *Health Promotion*, CD43/14 (PAHO 2001). Also important is the positioning of health promotion in subregional integration forums such as the XVIII Meeting of the Health Sector of Central America and the Dominican Republic (RESSCAD) in COR on 1-5-2002 and the Meeting of Ministers of Health of the Andean Area (REMSAA) #386, 2002.

19. Direct technical cooperation has contributed to national expertise in policy-making and facilitated interchanges between countries through networks of individuals and institutions working to promote healthy spaces: municipios, schools, housing, the network of Collaborating Centers and Centers of Excellence in health promotion, including the Inter-American Consortium of Universities, to improve the training and development of professionals in health promotion. The preparation of methodological guidelines for strategic planning and the evaluation of activities in health promotion are areas that have also been targeted for cooperation with the countries, as has the preparation of reports on progress and institutional capacities in health promotion in 2002 and 2005. Other agencies have also joined efforts in health promotion, among them the United Nations Children's Fund (UNICEF), the United Nations Food and Agriculture Organization (FAO), and the World Food Program (WFP), which have contributed to the Health-promoting Schools Initiative; and the United Nations Educational, Scientific, and Cultural Organization (UNESCO), whose agreement with PAHO has helped train trainers

to improve education in health and life skills in schools. The United Nations Development Program (UNDP) has helped strengthen community action and support local development, while the United Nations Environment Program (UNEP) has helped improve basic sanitation and environmental health.

Putting Health Promotion on the Health Agenda

20. These past 20 years have witnessed significant advances in the recognition of health promotion as an essential public health strategy and function. However, real progress in putting it on the health sector agenda and making it part of development plans has proven difficult. Nevertheless, major efforts have been made to develop the national health promotion plans outlined in the Mexico Statement. *Vida Chile* is considered the most complete example in Latin America, and Chile is the only country to have implemented a national plan of action for health promotion in line with the Mexico Statement. Uruguay has established its national health promotion plan. Canada has a decentralized system under which many provinces have provincial health promotion plans, with resources and very creative, comprehensive programs. Peru and other countries have developed policies and strategies that, while without being national plans, are distinctive for their genuine commitment to lines of action for health promotion.

Challenges to Developing the Health Promotion Strategy

21. The advances in health promotion in the Region reveal the importance of all the processes emanating from the Ottawa Charter, as well as the diversity of the results according to each country's context; however, some constraints and problems should be examined in-depth in order to develop strategies and mechanisms for the consolidation and sustainability of these results in the Region.

22. One difficulty is related to the domain of health promotion activity. Since it is a "new paradigm" based on the WHO concept of health as well-being and not the mere absence of disease, it has a broader sphere with a multisectoral perspective that extends beyond the health sector, just when state reforms have weakened the position of health vis-à-vis other sectors[7]. It is still common for professionals and politicians to have trouble differentiating the specific nature of health promotion from disease prevention activities. In many countries, programs are called "health promotion and disease prevention" programs as if the two areas were a single aspect. What is the difference? Where does prevention end and promotion begin? Is the line between the individual and collective

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[7] Regarding the WHO concept, a concept so broad runs the risk of becoming the ideal objective of (and is certainly affected by) all human activity. It leaves no room for a separate, identifiable domain of activity specifically targeted to health. (Evans, T. et al. Challenging Inequities in Health). Oxford U. Press, 2001).

approach or between the disease/risk approach and the health approach from a positive perspective?

23. Another aspect is related to the identification of the health sector's role in the development of health promotion. In the Declaration of Santa Fé de Bogotá (12), health promotion is a strategy for seeking conditions that will guarantee general well-being as the basic purpose of development. Consequently, the challenge of the health promotion in Latin America is to transform those relationships, reconciling economic interests with the social goal of well-being for all and promoting solidarity and social equity. The health sector has the vital role of collaborating with other sectors in strategic health promotion activities, thus improving the quality of life and equity.

Positioning Health Promotion in a Globalized World

24. Intersectoralism and public policy are the foundation of health promotion. However, health sector resources are rarely used to promote intersectoral activities, and it is very difficult to influence public policies that are generally related to public health. Governments and regional, subregional, and national Centers of Excellence in the countries require health promotion activities that address health determinants.

Institutional Positioning

25. The Millennium Development Goals (MDGs) are a great opportunity to increase investment in health promotion and improve equity in health. The work of the Global Commission on Social Determinants of Health represents a unique opportunity to develop and implement public policies consistent with the provisions of the Ottawa Charter and the successive documents leading up to Bangkok.

- The ministries of health should exercise their responsibility as the national public health steering agency in intersectoral environments to promote health and maintain good practices and the initiatives, especially the healthy settings and healthy spaces initiatives.

- Within the Ottawa framework, it is essential to invest in the reorientation of health services to make them better able to foster health promotion and promote public health from within the sector.

26. A key aspect of health promotion is the capacity to bring people and institutions together in academic and public forums that help to put this perspective on the public health and development agenda. At the community level, the need to connect health promotion activities with other health service activities should be stressed, along with the strengthening of mechanisms to encourage the participation of the community (social capital) to further its autonomy and empowerment.

27. Although the Region has seen many initiatives and resolutions to address in one way or another the social determinants of health (poverty, education, nutrition, and basic services), it is certain that economic, cultural, environmental, and political conditions, as well as inequities, are still a real challenge for all the countries. The recent creation of the Global Commission on Social Determinants of Health, as well as the commitments of the Bangkok Charter, have put this important issue on the health promotion agenda.

Institutional Capacity Building

28. The Member States continue requesting technical assistance and follow-up from PAHO to strengthen their institutional capacity in health promotion. Since the Jakarta conference, greater efforts have been made to forge intersectoral partnerships with a view to making health promotion activities more effective. Since the Mexico conference, efforts to evaluate the effectiveness of health promotion and the health impact of public policies have increased. Public opinion as an instrument for changing conditions and lifestyles has become more visible, inspiring social participation in education and communication activities to promote healthy behaviors. PAHO has collaborated in the reorientation of health services to ensure that they include health promotion activities.

PAHO Support and Monitoring of the Commitments in the Bangkok Charter

29. The Secretariat intends to engage in a broad consultation to develop a future plan of action that will strengthen the institutional capacity of the Member States to promote the health. This plan of action should include mechanisms for monitoring and evaluating performance through consensus-based indicators and objectives. The Bangkok Charter encourages governments, communities, health professionals, the private sector, and all those involved to work together for to promote health as part of a global effort to meet the commitments to guarantee health for all: to make health promotion a critical item on the global development agenda, an essential responsibility of the entire government, a basic objective of communities and civil society, and a prerequisite of good business practices.

Action by the Executive Committee

30. The Executive Committee is requested to review the progress in health promotion in the Member States and to offer recommendations on the path to follow in the construction of a health promotion agenda in a globalized world.

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