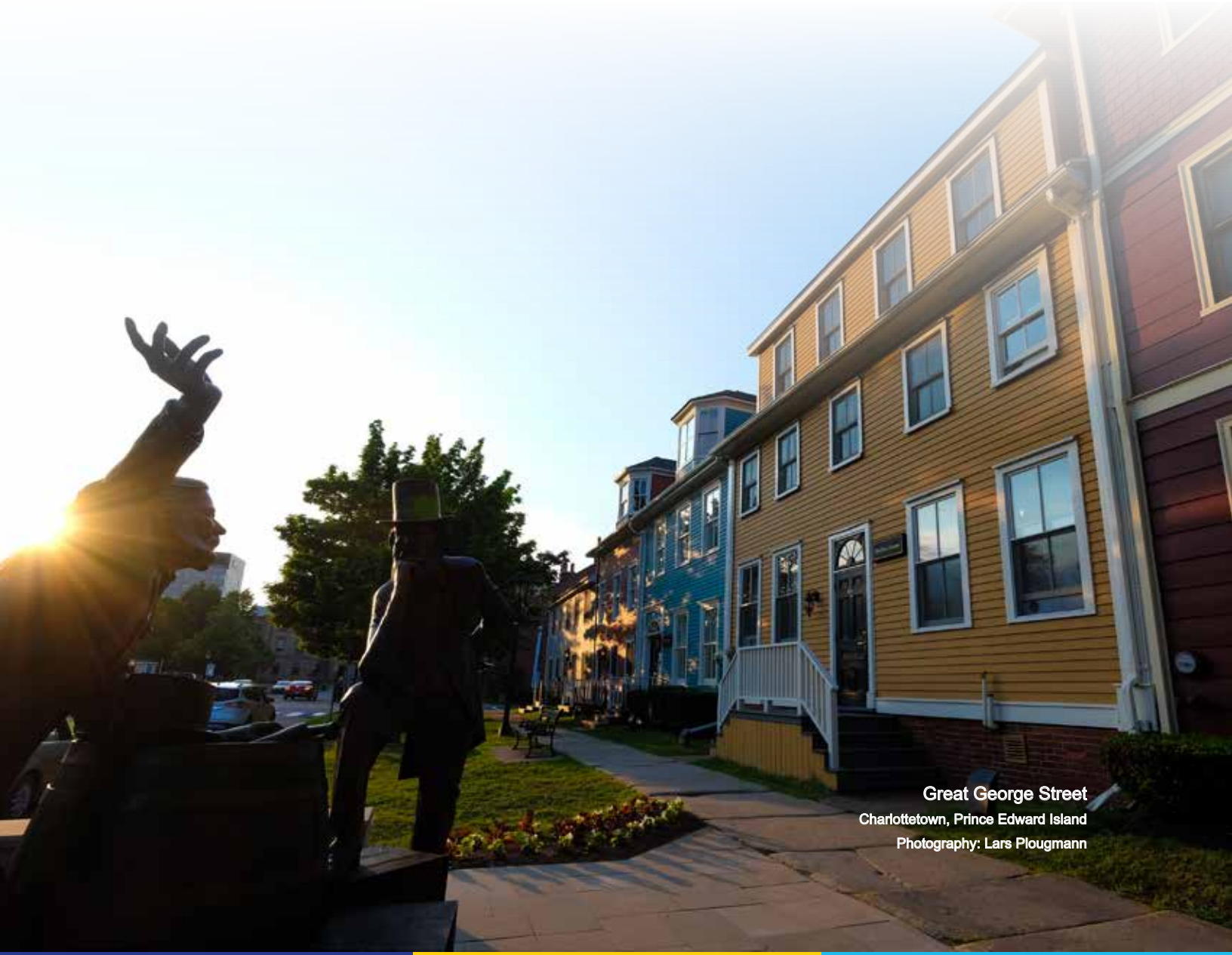
6th Global Forum on
HEALTH PROMOTION

6e Forum mondial sur la
PROMOTION DE LA SANTÉ

Health Promotion
Preliminary Research Report

Looking Back ... Moving Forward



Great George Street
Charlottetown, Prince Edward Island
Photography: Lars Plougmann

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6th Global Forum on Health Promotion

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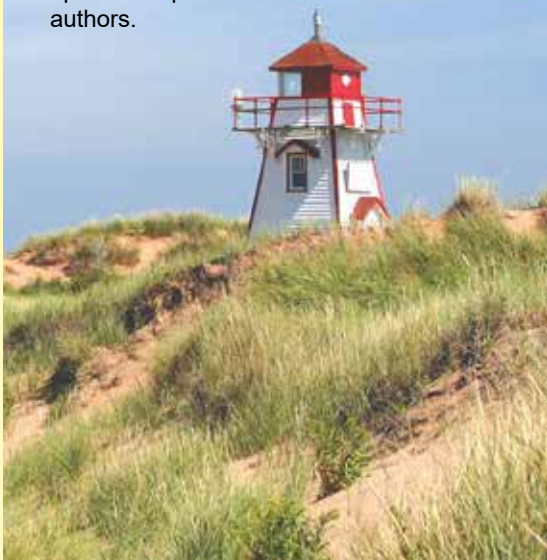
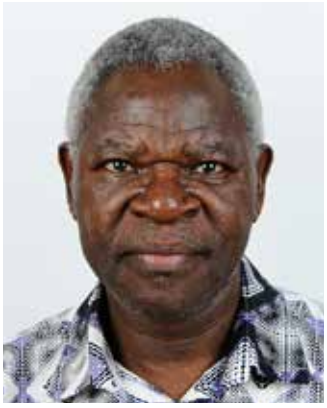


Foreword



By Bernard Kadasia, President, Alliance for Health Promotion

High quality research to generate and process knowledge and information is key to successful policy development, advocacy, learning, programming and accountability. At the same time, research requires *conviction*: first and foremost, conviction about the worth of the research; and secondly, conviction to commit and allocate resources to it amid many competing and more urgent or established demands. Overall therefore, far too little research of the right quality is carried out. The result is an inadequacy of data and evidence for decision making. This problem afflicts the global health sector probably more than it does others. Health Promotion is particularly affected because it is relatively blurred - conceptually and operationally. Additionally, there is no big money in Health Promotion, generally speaking. Regardless, Health Promotion Research is stronger in both quality and quantity in educational settings and in publishing than it is in programme implementation. Over the years I have heard my Civil Society colleagues remark anecdotally, and mistakenly, that they are too busy doing the actual work and have little time to collect data and analyze impact.

The Alliance, like all players in Health Promotion, badly needs good research for two reasons: to effectively advocate for Health Promotion, including the provision of evidence of the successes of the approach; and to support the Health Promotion work of its members with new information and technologies.

When planning the 6th Global Forum on Health Promotion, the organizers saw a rare opportunity to contribute to addressing the challenge of inadequate and low-quality research for Health Promotion. It was agreed to commission a modest research study to review the experience of Health Promotion over the last 30 years – since the first Global Conference on Health Promotion held in Ottawa in 1986. It was further agreed to focus the study on Civil Society – role, achievements and experiences.

We were lucky that our friend and colleague Jean-Pierre Girard agreed to take on this unenviable task. Jean-Pierre has had a distinguished career in academia, civil society, social economy, health and development at the local level in Quebec, at national level in Canada and at international level. He is passionate about research and a firm believer

in empowering communities and individuals to take control of their own lives. He has ably put these attributes to the benefit of the project and the report.

This report is important and timely. It comes at a time when the Health Promotion world is commemorating and celebrating the 30-year Anniversary of the seminal Ottawa Global Conference on Health Promotion and the resultant Ottawa Charter. Enough time has passed to make a meaningful review of what the Charter has meant and how it has impacted global health promotion work and outcomes. It is also a time when the world has just worked and adopted a global agenda for the next 15 years encompassing the Sustainable Development Goals. It is an agenda in which Health Promotion will play a significant role.

You will find the discussion of the evolution of broader civil society over the centuries enlightening. In this evolution one can find part of the explanation for the role and performance of civil society in Health Promotion. Examples of how civil society, including the Alliance, has worked and some of the outcomes of that work are well presented in the report. Some of them, like the Circle of Health, *Hans Kai*, Healthy Enterprise and community-level workshops, are quite innovative and potential game-changers.

We in the Alliance are very excited about this project and report and foresee that it will be the trigger for more research by the Alliance between now and next year when we shall be celebrating 20 years since our founding. And that it will stimulate a new awakening in our members, in the participants on Prince Edward Island and in Shanghai so that we can see research and investigation become a regular activity among civil society organizations in Health Promotion. Beyond that, the report should be useful in informing our work for the coming years.

Acknowledgments

This preliminary research report is not the work of one person – far from it. In fact, it is the result of a collaboration, with numerous contributors I want to recognize.

Above all, my thanks go to the authors of the various documents compiled in this report. In this regard, note that some were originally published in the pages of *SpiritualitéSanté*, a publication of the Centre hospitalier universitaire de Québec. Happily, in spring 2016 the editors of this magazine took the initiative to publish an issue on the topic of health promotion, needless to say, on account of the 30th anniversary of the Ottawa Charter. I would be remiss not to acknowledge the effective cooperation of the magazine's editorial committee, especially its editor-in-chief, Bruno Bélanger.

At short notice, the president of the Alliance for Health Promotion, Bernard Kadasia, kindly agreed to write the report's foreword. He shares with us there his rich experience in terms of health promotion and civil society organizations, both locally and internationally.

The editing and layout were deftly handled by Don McNair. His meticulous review and correction of the English version also bear mention.

Finally, the collaboration of the members the forum's steering committee was much appreciated: Jeane Day, Laura Lee Noonan, Patsy Beattie-Huggan and Gabriella Sozanski. Their comments and suggestions have enriched the content.

This report is called "preliminary" for a reason: I invite its readers to share their ideas with the secretariat of the Alliance. They could fuel a subsequent version of this report in 2017, the twentieth anniversary of the Alliance!

Happy reading!

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Member of the Board, Alliance for Health Promotion
Member of the Board, Health Nexus Health

Peakes quay in Charlottetown
(Photo: Qyd)

Introduction

By Jean-Pierre Girard

It was 30 years ago that more than 200 participants from 38 countries gathered in Canada's capital at the initiative of the WHO, the federal Ministry of Health and Welfare and the Canadian Public Health Association for the first major international conference on health promotion. At its conclusion the participants adopted what is commonly known as the "Ottawa Charter for Health Promotion." This is not an act of foundation, the statements and thoughts of previous years having established the fundamental principles of the Charter; rather, it was a turning point. It was a hinge between past and future, because it pooled the principles and ideas that already had been discussed or were evolving around five major strategies and expressed a vision of the future – a future committed to creating supportive environments, developing personal skills, and much more.

In a way, the Charter was a tremendous plea to extricate health from the sole embrace of the medical profession and state action. Through the promotion of health, the Charter forges an understanding of health that transcends the merely hospital-centric or curative approach and recognizes the importance of what then was called "community action." Although the term "civil society" was not yet in common use, the Charter manages to legitimize the actions of these organizations, variously called associations, nonprofits, non-governmental organizations and the like; what's more, it moves people to action! Indeed, it must be remembered that in the wake of the Charter's adoption, citizens in several countries came together to undertake one or another of the strategies it articulated. Over time, especially with the Bangkok Charter for Health Promotion (2005), the term "civil society" gained greater recognition. In 2016, nobody can overlook the action taken by civil society in local as well as international issues!

This preliminary research report aims to feed reflection on a 30-year journey to the confluence of civil society and health promotion. The journey falls into three parts.

We started with some background papers. In the first, we review the major conferences on health promotion, from Ottawa (1986) to Shanghai (2016). This helps to clarify how the ideals in the various charters evolved as a result of discussions and compromises on the international stage between governmental, research and civil society actors. In one way or another, the offspring of these major conferences, the Alliance for Health Promotion, came into being in 1997. A second document takes it from then until now, exploring its various actions in support of the Ottawa Charter. This section concludes with a third document, a retrospective on initiatives supportive of health promotion in Canada over the period 1986-2016.

The second part of this report consists of a substantive analysis of two very current issues: the relationship between civil society and health promotion, and a study of the Sustainable Development Goals of the United Nations (adopted in New York in September 2015) through the lens of the strategies of

the Ottawa Charter. These documents make no claim to being the final word on these subjects. Rather, they aspire to stimulate reflection and exchange in order to move our thinking to the next level. In other words, it is not a static proposition, but a dynamic one, meant to change over time, fuelled by ideas and debate!

The last section of this report provides an opportunity to learn about four initiatives in Canadian health promotion. The four offer a panorama of Canadian diversity, with one from the country's West, two from its centres of population, Ontario (Nexus) and Quebec (Groupe entreprises en santé), and a fourth from the Maritimes (The Circle of Health). In fact, one of these cases (the *Hans Kai*) is not completely Canadian; rather, it originates in Japan and has been adapted to the Canadian milieu! Together these cases offer us a variety of environments, with different approaches to diverse clientele: in workplaces, supporting systemic and holistic approaches to at-risk populations, pregnant women or young mothers. In sum: a rich panorama of health promotion in all its diversity!

PEI Convention Centre
Charlottetown, Prince Edward Island

WHO Global Conferences on Health Promotion

From Ottawa to Shanghai: An Overview of Declarations and Recommendations Concerning Health Promotion (1986-2016)

By Jean-Pierre Girard and Gabriella Sozanski

It is certainly no accident that today health is generally understood to be the product of more than the density and distribution of medical clinics across a given territory or indeed access to a family doctor, as important as these two factors may be. The concept of health has evolved over the ages, as a consequence of beliefs, ideologies, thoughts and research. But it is appropriate at this time to dwell on one particular journey in the conceptualization of health, that of a series of major international conferences held under the leadership of the World Health Organization (WHO) specifically on the subject of health promotion. Beginning in Ottawa in 1986, this series will mark its thirtieth anniversary this fall at the 9th International Conference in Shanghai, November 21-24, 2016.

By means of charters, declarations and recommendations, the purpose of this paper is to track this journey, punctuated by eight conferences as well as other international events, which may have had a significant impact on the concept of health promotion and, more generally, on the concept of health itself. Our purpose also is to examine the clarity and relevance of its starting point, the Ottawa Charter, adopted at the conclusion of the first conference. In addition, we want to reflect on the growing influence of civil society non-governmental organizations (NGOs) in this series of major conferences.

Note that, as a summary of 30 years of international conferences, this reflection has omissions. It is our intent only to indicate certain milestones in this journey and to conduct a very rough assessment of the progress made to date.

Ottawa 1986: a Departure & an Arrival

Before addressing any issues regarding health, including health promotion, the Charter identifies four factors essential to health: peace, shelter, food and income. With the benefit of hindsight, we can recognize in these factors and other contributions, like Dahlgren and Whitehead's layers of influence on health,[1] an outline of what in 2008 will be identified as the social determinants of health. But why aim for good health in the first place?

> *Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it.*[2]

What then is meant by health promotion? This is no trivial matter. As the first formal definition this concept would receive in the context of a

[1] Dahlgren, G., and M. Whitehead. 1991. *Policies and Strategies to Promote Equity in Health.* Stockholm: Institute for Future Studies.

[2] World Health Organization. "The Ottawa Charter for Health Promotion ... 21 November 1986." Geneva: World Health Organization. Retrieved September 13, 2016 (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html).

major conference, the following stood to gain wide acceptance:

> *Health promotion is the process of enabling people to increase control over, and to improve, their health. 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 is, therefore, seen 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. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.*[3]

Health promotion seeks to encourage equality in terms of health. In this sense, it roundly affirms the need for action on the determinants of health and in particular on the social determinants of health, being social and economic conditions that influence people's lives.

Such action should unfold around 5 key strategies:

- *Build Healthy Public Policy*
- *Create Supportive Environments*
- *Strengthen Community Actions*
- *Develop Personal Skills*
- *Reorient Health Services*[4]

In terms of implementation, the Charter specifies that *health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change.* A policy of health promotion must identify barriers in areas outside the realm of health and take appropriate measures to neutralize them.

The Charter is thus infused with the values of humanitarianism and solidarity. Like the Universal Declaration of Human Rights adopted in 1948, it is inspired by an ideal of global coexistence and collaboration that transcends borders, languages, cultures, religions and beliefs.

If in some respects, the Ottawa Charter can be seen as a point of departure, it ultimately is one of arrival, as well: it is generally accepted that the ideas that animated the Charter had been circulating for several years in schools of public health. The Ottawa Charter in some way crystallizes the idea that health policy should no longer be confined to advancing access to care and quality of care.

1986-2005: From the Ottawa Charter to the Bangkok Charter

Noteworthy in the recommendations of the Second International Conference (Adelaide, Australia, 1988) is a clear concern for social justice and equity as prerequisites for health. The priority actions target women's health, food, issues of tobacco and alcohol consumption, and the importance of creating environments favourable to health. The declaration of the third conference (Sundsvall, Sweden, 1991) returns to this notion of environment, especially with respect to social isolation and participation. Thus, when observing the upheaval of cultures and the values that animate societies, the development of new lifestyles frequently is associated with rising social isolation which necessarily leads to loss of direction and coherence in individuals' lives, and ultimately undermines their health. But participation is not brought about by mere slogans or dramatic appeals. It must be

[3] Ibid.
[4] Ibid.

manifested by specific actions on the part of governmental authorities. It must be demonstrated not only through consultation but also in terms of decisions and by a decentralization of responsibilities and resources. What is getting formulated here, in other words, is the idea of subsidiarity.

Although it falls outside the realm of conferences on health promotion, the United Nations Conference on Environment and Development or "Earth Summit" in Rio de Janeiro (1992), underlines the urgency of the idea of sustainable development. At its very heart lies the issue of the survival of diverse living species, humanity being one of them.

The Jakarta Declaration (1997, Indonesia) explores the impact of economic globalization on the health of individuals. It also refers to Healthy Cities, to the challenge of healthy aging and to workplaces that respect the principles of health and safety. Interestingly, private companies at this conference committed themselves to working in collaboration with the WHO, governments and NGOs to encourage greater adherence to these actions on the part of other private companies.

It was also an opportunity to invite numerous NGOs to actively participate in discussions. In the same vein, on the sidelines of the World Health Assembly in Geneva (1998), the WHO held the first information meeting for NGOs on the subject of health promotion. Since that time, this annual event has been coordinated by the Alliance for Health Promotion. In 2015, the WHO executive board admitted the Alliance into Official Relations with the WHO.

The Mexico Declaration (2000), for its part, highlights the social responsibility of health. It appeals for community capacity in health and calls for building health promotion into all health policies.

The Bangkok Charter adopted on August 11th, 2005 at the end of the sixth international conference on health promotion, recognizes the importance of the Ottawa Charter and the recommendations made in various declarations. At the same time, it calls for a development of a Charter more in line with the challenges of the 21st Century. In short, the Bangkok Charter identifies the actions and commitments required to deal with the determinants of health in a globalized world through the promotion of health:

- *advocate for health based on human rights and solidarity*
- *invest in sustainable policies, actions and infrastructure to address the determinants of health*
- *build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy*
- *regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people*
- *partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions*[5]

It also specifies four key commitments to

[5] World Health Organization. "The Bangkok Charter for Health Promotion in a Globalized World (11 August 2005)." Geneva: World Health Organization. Retrieved September 13, 2016 (http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/).

enhance health promotion. Health promotion must be …

- *central to the global development agenda*
- *a core responsibility for all of government*
- *a key focus of communities and civil society*
- *a requirement for good corporate practice*[6]

Thus, the Charter recognizes how community and civil society organizations and women's collectives have demonstrated their effectiveness in health promotion, and that their programs should serve as an inspiration to others.

It was in Bangkok that the Alliance (then called the NGO Advisory Group on Health Promotion) made its first official statement at a WHO conference on health promotion. The Alliance expressed its appreciation for the partnership that WHO had offered NGOs and called for a closer working relationship: "Our global reach and local presence put us in a position to be key partners and to create synergy in the process of disseminating the Charter and to play a pivotal role in its implementation." This statement explicitly calls upon the WHO to strongly endorse the role played by NGOs in health promotion.

2008-2016: Nairobi to Shanghai

The report *Bridging the gaps in a generation: health equity through action on the social determinants of health*, published by the WHO in 2008, was the fruit of several years of work by the Commission on Social Determinants of Health. The report makes three major recommendations:

- *Improve the conditions of daily life.*
- *Tackle the inequitable distribution of power, money and resources.*
- *Measure the problem, analyze it and evaluate the impact of action.*[7]

This report explains that health resources (clinics, professionals, medicine, etc.) have only a limited impact on the health of individuals, and how an array of elements relating to education, employment, and the environment, among others, "determine" the health of individuals. It is a contribution not to be overlooked in the context of the major issues concerning health promotion which have arisen since the Ottawa Charter of 1986.

Nairobi, Kenya (2009) was the venue for the seventh conference, and for the first major conference to be held on African soil. The proceedings look back on the 2008 financial crisis and its negative impact on health systems. Furthermore, it highlights the impact of climate change on humanity, especially in low-income countries. Given this context, health promotion is seen as imperative. Remember that since the Ottawa Conference, research results have demonstrated that health promotion is an integrative, cost-effective strategy and an essential component of any health system that is highly responsive to emerging issues.

At the Nairobi conference, the Alliance was responsible for organizing a session integral to the program on the role of civil society. The session drew over 100 participants. Not only that, the Alliance was able to mobilize 50

[6] Ibid.

[7] Commission on Social Determinants of Health. 2008. *Closing the gap in a generation: health equity through action on the social determinants of health.* Geneva: World Health Organization. Retrieved September 13, 2016 (http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf).

NGOs which all received invitations to attend the WHO conference.

Community empowerment, a key element in the participation of civil society organizations in health promotion, is more than a strategy of participation. It is a process that involves a re-negotiation of power for purposes of exercising greater control. Participatory approaches that encourage discussion and debate develop the knowledge base and critical thinking.

Recognizing that all policies have an impact on health, the eighth conference (Helsinki, Finland 2013) took as its theme "Health in All Policies." Three major actions were proposed:

- *Prioritize health and health equity as a core responsibility of governments to their peoples.*
- *Affirm the compelling and urgent need for effective policy coherence for health and well-being.*
- *Recognize that this will require political will, courage and strategic foresight.*[8]

Organized by the municipal authorities of Shanghai, the 9th Conference on Health Promotion will be held November 21-24, 2016 at the Shanghai International Convention Centre at the initiative of the WHO and the China National Health and Family Planning Commission. The theme will be the promotion of health and sustainable development goals through four courses of action: healthy cities, cross-sectoral activities, social mobilization and health literacy. The topics of youth and innovation are also on the agenda.

[8] WHO. "The 8th Global Conference on Health Promotion, Helsinki, Finland, 10-14 June 2013." Retrieved September 13, 2016 (http://www.who.int/healthpromotion/conferences/8gchp/statement_2013/en/index1.html).

Conclusion

What can be said about the path we've trod in the 30 years since the Ottawa Charter? In terms of assets, one cannot underestimate the momentum which that first conference delivered to its successors. More specifically, the Ottawa Conference launched a recurrent process of international mobilization around the issue of health promotion, including the exploration of factors inherent to the advancement of this cause. Furthermore, the themes of subsequent conferences disclose their affiliation with the key ideas of the Charter, for example, Helsinki's theme of "Health in All Policies" in 2013. Nor can we underestimate their impact on other developments, such as the report of the Commission on Social Determinants of Health. In fact, in retrospect, there is a perceptible convergence of the challenge of health promotion with that of the social determinants of health. Finally, consider the general understanding of what constitutes "health." In 2016, can you imagine a debate on population health that excludes the impact of climate change, the education system, etc.? The answer is obvious.

In terms of liabilities, despite regular efforts to re-affirm in public debates the importance of health promotion, too many examples come to mind of health systems spiritually entrapped in what is called the "hospital-centric" or "biomedical" approach. Thus, public opinion is moved more easily by undue delay in patient emergency treatment than by massive cuts in health promotion programs. Ditto for a substantial investment in sophisticated medical equipment as opposed to an awareness campaign against HIV/AIDS in a disad-

vantaged neighbourhood. It's obvious, some might say: in one case, you see an immediate effect whereas in the other, the effect is more difficult to measure. That said, it is demonstratively more profitable to invest in health promotion than in expensive medical treatments. The reorientation of health services from a curative approach to a preventive approach is no simple matter!

Community action won acclaim years ago. Numerous instances, in low-income as well as high-income countries, testify to its effectiveness in health promotion. However, the mobilization of resources around this issue remains a challenge. To name just one of many examples, how difficult it is for NGOs to secure adequate multi-year funding to accomplish such a mission. The exercise of social democracy in regard to health is something which public health authorities often have at best an imperfect understanding.

In sum, since the adoption of the Ottawa Charter in 1986, the results have been patchy. Some will say that the glass is half empty. We believe it is half full – and that means redoubling our efforts to fill it to the brim!

The Legacy of the Ottawa Charter

as reflected in the activities of the Alliance for Health Promotion or The Alliance for Health Promotion: From Ottawa to the SDGs

By Laura Foschi, Clélia Romy and Gabriella Sozanski

> *"No one should be denied access to life-saving or health promoting interventions for unfair reasons, including those with economic or social causes."* Margaret Chan - Director-general of the World Health Organization (2008)[1]

In 1997 at the 4th Global Conference on Health Promotion of the World Health Organization (WHO) in Jakarta, a group of committed non-governmental organizations (NGOs) formed an Ad Hoc Advisory Group on Health Promotion. They realized that, in order to achieve progress in health promotion and to implement conference outcomes, NGO support and action would be required. Among the founding members were organizations representing a range of sectors, including education, health cooperatives, social welfare, research, health professionals and traditional practices.

Since its establishment, this Advisory Group has focused on the objective of taking international declarations to the grassroots and, in return, bringing local knowledge back to the international level. It also has developed into an international NGO: the Alliance for Health Promotion, with a registered office in Geneva, enjoys Official Relations with the WHO and Consultative Status with the Economic and Social Council of the United Nations. All this was made possible through a close collaboration with and support from the WHO while the Alliance built up a solid network of community ties and grassroots contacts.

The strength of the Alliance lies in the fact that it serves as a bridge between global and local knowledge. Since 1997 the Alliance has organized Annual Briefings concerning a primary agenda item at every World Health Assembly. The Alliance aims to have its voice heard at meetings of the WHO governing bodies and other relevant forums. At the 6th Global Conference on Health Promotion in Bangkok in 2005, for instance, the Alliance was the only NGO to make a plenary statement.

In Nairobi in 2009, during the 7th Global Conference on Health Promotion, the Alliance was commissioned to coordinate a sub-plenary session on Civil Society.

The Alliance aspires to see empowered individuals and mobilized communities become agents of change with the knowledge, authority and means to better control their health, attain health literacy and enjoy a healthy lifestyle. Its mission is to bridge the gap between international declarations and local realities by advocating a holistic approach to health and by engaging in a multi-sectoral and inclusive process to promote health.

To fulfil its role and carry out its activities the Alliance relies on four pillars: consultative meetings with NGOs during sessions of the WHO Executive Board; Annual Briefings at the World Health Assembly; Regional Health Promotion Workshops (Kitale, Bangalore); and Global Forums on Health Promotion in

[1] Chan, M. 2008. "Global health diplomacy: negotiating health in the 21st century." Geneva: World Health Organization. Retrieved October 1, 2016 (http://www.who.int/dg/speeches/2008/20081021/en).

Geneva. The Global Forums provide a platform for NGOs, academia and government to exchange views on priority issues in global health promotion. This year, 2016, is the first time that the Global Forum will be held outside of Geneva, in Charlottetown, Prince Edward Island (Canada), in celebration of the 30 years since the adoption of the Ottawa Charter at the WHO's First International Conference on Health Promotion.

While organizing its activities the Alliance pays particular attention to the reinforcement of human rights, for access to health is a human right under the WHO Constitution, the Universal Declaration of Human Rights (1948) and the Alma-Ata Declaration (1978). The use of inclusive, horizontal communication to achieve a positive impact on policy and decision-making is crucial to the accessibility of health.

The concept of health promotion developed by Dr Aaron Antonovsky is based on an approach that he termed "salutogenics"[2] (derived from "salus," meaning "health" in Latin, and "genesis," meaning "origin" in Greek). Health promotion is about taking into consideration new discoveries and adopting new frameworks. Great potential lies in the development of epigenetic therapies[3] which are important for health promotion interventions.

Thirty years ago in 1986 the WHO launched the modern iteration of health promotion at the landmark conference in Ottawa:

> *Health promotion is the process of enabling people to increase control over and to improve their health.* Ottawa Charter, 1986

[2] Antonovsky, A. 1996. "The salutogenic model as theory to guide health promotion." *Health Promotion International* 11(1):11-18. Retrieved October 1, 2016 (http://heapro.oxfordjournals.org/content/11/1/11.short?rss=1&ssource=mfc).

[3] Therapies that restore the effectiveness of tumor suppressing genes.

The world has undergone major political, economic and social changes since 1986. There has been a major shift in global power relations, global health governance and the economic model. The reduction of health inequities and Social Determinants of Health (SDH) have come to the forefront, emphasizing the importance of human development to the global health agenda. This is particularly significant when we appreciate that health promotion has experienced much the same trajectory as the SDH in the reduction of health inequities, thus providing an opportunity for health promotion to reclaim its space in the global health and development agenda.

It has become obvious that successful health promotion requires an approach which relies on the SDH, including gender, socioeconomic status, built environment, working conditions, education level, marital status and religion

The Alliance has been actively engaged in the post-2015 development agenda process while continuing to build on the five key strategies identified in the Ottawa Charter, namely, build healthy public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services.

The WHO's definition of health, enshrined in its Constitution in 1948, expresses a global and positive understanding of health, implying health promotion and the SDH, and not merely the absence of disease.

> *Health Promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better heath with the strengthening of the individual and the group.* Ottawa Charter, 1986[4]

[4] World Health Organisation. 1986. "Ottawa Charter for Health Promotion." *Health Promotion International* 1(4):405. Retrieved October 1, 2016 (http://heapro.oxfordjournals.org/content/1/4/405.2.full.pdf+html).

Since its inception, the Alliance has been working tirelessly along the lines of the Ottawa Charter's five key strategies. The following are some of the strongest links between the Ottawa Charter and the Alliance's thematic record of activities.

Community empowerment has always been at the centre of Alliance activities. In order to achieve increased impact, the Alliance partnered with the Afro-European Medical and Research Network (AEMRN) to launch the first Regional Workshop on Health Promotion, linked to the mobile clinics organised by AEMRN in Kitale, Kenya. This happened immediately after the WHO's 8th Global Conference on Health Promotion in Helsinki in 2013. This event was an opportunity for the Alliance to raise awareness about the Statement on Health in All Policies adopted at the Conference and to assess how local communities interpret and apply it. At the same time Workshop participants (representing a wide spectrum of community leaders including government, health professionals, traditional healers, local associations and school teachers) were able to identify the most pressing health issues, such as HIV, respiratory infections, diabetes and cancer. These were addressed and discussed during the Workshop and/or afterwards. Workshops are still being held every year in Kitale.

As another priority, the great number of injuries and deaths due to road accidents were identified in 2014. As a follow-up, one partner NGO launched a driving school and another built sheds for passengers and showers for drivers in Kitale. This issue of road safety can be linked to one of the key strategies of the Ottawa Charter, namely "build healthy public policy," in the sense of empowering local people to have a say in public policy changes.

Overall, the work of the Alliance revolves around the whole spectrum of Sustainable Development Goals (SDGs). Well before they were adopted, the Alliance had addressed multiple aspects of sustainable development during its meetings and conferences.

Looking back to the 7th Global Conference on Health Promotion in Nairobi, Kenya in 2009, the Alliance recognizes the importance of having organized – as an official partner of the WHO – a sub-plenary session on "Civil Society and NGOs: closing the implementation gap." At the time, the conference was addressing the themes related to what would become SDG 16 ("Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels") and SDG 17 ("Strengthen the means of implementation and revitalize the global partnership for sustainable development").

A parallel can be drawn between the recent activities of the Alliance and the SDGs. Two events organised in 2015 focused on the impact of technological progress on health. This does not appear in the Ottawa Charter, but is integral to the SDGs: the 4th Regional Health Promotion Workshop in Kitale, Kenya**,** entitled "Making Communications (Technology) Work for Health Promotion"; and the 5th Global Forum on Health Promotion in Geneva, "Closing the Gap in Health Equity through Technology." The outcomes of these two sessions overlap with SDG 9 ("Industry, innovation and infrastructure**")** as well as SDG 7 ("Ensure access to affordable, reliable, sustainable, and modern energy for all").

This focus on technology is extremely opportune. The deployment of new, affordable and sustainable technologies such as m-health, apps, e-health, telemedicine and other

non-conventional tools, is fundamental in local settings and in community programmes.

In terms of community empowerment but also capacity building, a major step forward has been the creation of a local association, the Alliance for Health Promotion Kenya (2016). Its establishment was proposed by the participants of the Regional Health Promotion Workshops in order to increase outreach and awareness around health promotion and to take greater control over their own health through local action. Its purpose, in a word, was to make their programmes sustainable.

The latter is an outstanding example of a bottom-up initiative, driven by social mobilization and by a determination to achieve better community health outcomes. In fact, the whole process leading up to the creation of the Alliance for Health Promotion Kenya reflects the principles of the Ottawa Charter, and three key strategies in particular: create a supportive environment, strengthen community action and develop personal skills.

The Kitale Model of social mobilization, community empowerment and increased awareness was an inspiration to Lakeside Education Trust, the Alliance's Founding Member from Bangalore, India. As a consequence, it proposed to include a health promotion component in its Annual Conference Programme. In July 2016 the Alliance was invited to give an overview of the landscape of global policy and practice, present the Kitale model and share its experience in the use of health promotion strategies to advance health equity and improve health impacts. The presentation was received with great interest by the health professionals, academics, researchers and community leaders in attendance. It was agreed to broaden collaboration to include other partners in Bangalore.

For the past two years, the Alliance has held a Health Promotion Day prior to the World Health Assembly. This enables international delegates and local associations to meet in a friendly environment and exchange information about what health promotion means in everyday life. In 2015 the focus was on health and happiness. "Maslow based his theory for development towards happiness and true being on the concept of human needs.[5]"Indeed, he positioned *self-actualization* at the top of his famous pyramid. Thus, it can be said that the urge to experience purpose, meaning, and creativity – happiness – also has a significant impact on health. It too is "on the agenda." The Alliance has forged ahead with this initiative, and chosen "Walk our Talk" as the slogan of the 2016 Health Promotion Day.

The Alliance is excited to be co-organiser of the 6th Global Forum on Health Promotion in Charlottetown, Prince Edward Island, entitled "Health Promotion at the very Heart of Sustainable Development." The Alliance is exploring ways to transmit the Charlottetown Declaration, "A Call for Action: Health Promotion for Sustainable Development," to the WHO 9th Global Conference on Health Promotion to be held in Shanghai, November 21-24, 2016.

With the aim of moving Health Promotion forward, the Alliance and its members are eager to follow up these two important events, and are committed to take an active part in the implementation process.

2017 will be a special year for the Alliance. It will celebrate its 20th anniversary – an excellent framework for moving forward the Health Promotion Agenda in the era of SDGs.

[5] Ventegodt, S., J. Merrick, and N.J. Andersen. 2003. "Quality of Life Theory III. Maslow Revisited." *The Scientific World Journal* 3:1050-1057. Retrieved October 1, 2016 (https://www.hindawi.com/journals/tswj/2003/723673/abs/).

1986-2016 – A Retrospective on Health Promotion in Canada

By Pascale Leclair-Roberts

2016 marks the 30th anniversary of the Ottawa Charter for Health Promotion. The renowned document was the brainchild of the first international conference on health promotion, which took place in that city in November 1986. Within the charter, we find the field's core values and key principles, as well as five fundamental strategies of health promotion to support and enhance the health of populations: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services.

To celebrate this anniversary, experts were invited to share their thoughts and insights on the Ottawa Charter and the field of health promotion, 30 years on. Reflecting on their own experiences, Irving Rootman, Suzanne Jackson, Ann Pederson, Cameron Norman, Paola Ardiles and Sophie Dupéré shared what they viewed as some of the successes and lessons of practice over the last 30 years, as well as future opportunities for the field.

Before we begin, though, "What *is* health promotion"? Experts mentioned repeatedly that from an external perspective the term is unclear and does not provide insight into the work practitioners do. As Ardiles reveals, "There are a lot of people even within public health that still have the idea that health promotion is about lifestyle or health education." In reality, health promotion extends well beyond lifestyle factors. The field understands health in a holistic way, affected by determinants outside an individual's control: public policies, income, food security/insecurity, housing, education, race, gender, aboriginal status, early childhood development, and ecological environments, to name a few. What health promotion practitioners do is work in a variety of ways to improve factors that shape health and well-being, from supporting local communities with health promotion programs that improve the social determinants of health, to shaping policies that optimize population health.

Canada, the Ottawa Charter and Health Promotion: A Story

Canada has been a leader in the field for a long time, even before the introduction of the Ottawa Charter. In fact, one could say that the Ottawa Charter was born in part from this leadership. In 1974, the Canadian government published a report called *A new perspective on the health of Canadians,* commonly called the Lalonde Report, after the then Minister of National Health and Welfare, Marc Lalonde. The report introduced for the first time the holistic concept of health, redefining it as a combination of genetics, lifestyle and environment. It was also the first report to suggest that health could be improved through promotion efforts, kick-starting the field of health promotion. This avant-garde report quickly gained international notice and endorsement.

In Canada, health promotion grew rapidly in the years leading up to the Ottawa Conference. A great deal was accomplished, including establishing a federal Health Promotion Directorate and conducting the first national health promotion survey, which provided the empirical basis for practice. “That directorate was the first national directorate in the *world* to focus on health promotion,” says Rootman. “It was a model that other countries could and did follow.”

In the early 1980s, however, worry spread that practice was focusing too much on individual lifestyle behaviours and that practitioners were losing perspective on the new umbrella definition of health. This growing concern provided the incentive for the Ottawa Conference, and in the process, the realization of the famous Charter.

One of the first, and ongoing, successes of the Ottawa Charter has been its ability to bring together a complex and widespread practice. It gave the international health promotion field a focal point. “When I go to Brazil,” says Jackson, “they know the Ottawa Charter. If I go to Africa, or Taiwan, they know the Ottawa Charter. It’s as if everyone uses the same document globally, and they’re not many fields that you could say that you’ve got a document that forms the basis of people’s thinking *around the globe.*” The Charter unifies practitioners around the world, a unique element of health promotion practice.

In Canada, the Charter guided many meaningful initiatives, such as tobacco control. Without a doubt, tobacco control is the poster child of health promotion practice. As Dupéré remarked, Canada is home to some of the most restrictive tobacco regulations in the world, which not only protect the public from second-hand smoke, but also have supported Canadians in quitting smoking and lowering national rates. Our smoking rates are now among the lowest in the world, and the Charter’s values and strategies supported the field in achieving this significant change.

Health promotion also has countless other achievements to its name in Canada. Some of these are embracing cycling lanes in urban design; providing breakfasts and healthy foods in schools; creating the supervised injection site in Vancouver; increasing awareness and support of mental health; developing supports and networks for caregivers; subsidizing childcare in Québec and education across the country; prompting building codes to take physical disabilities into account; and pushing for the national inquiry of missing and murdered indigenous women and girls.

One could argue that the greatest success of the Charter and health promotion practice has been the ability to infuse health promotion language and concepts across a myriad of sectors and a wide range of policies. “We are seeing language like the Social Determinants of Health integrated in a number of different areas that are not health promotion,” says Norman. As a consequence, professionals in these fields advocate for a cause rooted in health promotion. “The exciting but also challenging thing about health promotion,” says Pederson, “is that it has a big lens, it crosses multiple domains. So you can work on health through being a poverty activist, or a gender activist, or an environmental activist, or you can be a specialist in immunization. There are all kinds of ways health is being promoted.” You can even be a health promoter through

government policies and documents, as recently displayed by Prime Minister Justin Trudeau in his mandate letters to ministers. Almost all of them use the principles or the very language of health promotion.

This success does have its challenges. Ardiles notes that since health promotion is "embedded in everything that we are doing, we lose ownership. In enabling others to do this work, we can lose that identification of the field, and then we run into this problem where people don't understand it or it's hard to identify exactly what it looks like." In addition to large-scale funding cuts and the closing down of many formal networks, such as the Canadian Health Network, the Canadian Women's Health Network and a number of Health Promotion Research Centres, the last 15 years or so have been demoralizing and frustrating for health promotion in Canada. The nature of the field already makes it difficult to contain it within a single sector, and the structural breakdown has made it even more difficult for experts to connect with each other.

On the other hand, it has pushed practitioners to adhere to other disciplines and shape the field into what Ilona Kickbush has referred to as a rhizome: a system characterized by innumerable roots expanding horizontally and without order, while simultaneously broadening its work and influencing its surroundings. And this unique shape is not a weakness; it is a strength. Ardiles explained that almost everything we have achieved to date can be attributed to this rhizome effect. The Charter has stood the test of time throughout this process, and people in other fields have taken it on, even if it isn't recognized by name. The Charter and its values are in everything that we do.

As for what the practice looks like in the future, nobody knows for sure. Five years ago when asked, "What can we expect for health promotion practice?" the answer was, generally, "more of the same." This year, the answer isn't as straightforward. It looks more like a big question mark. The majority win of the Liberal party in October 2015, along with the appointment of Dr. Jane Philpott (who holds a Master's degree in Public Health) as Minister of Health, generated a renewed sense of optimism in the field. However, many practitioners are cautiously taking a "wait and see" approach.

This doesn't mean they are idle. They are voicing loud and clear actions they would like to see happen in the near future, and changes this government could bring. Ideas put forward include re-introducing a pan-Canadian network to connect and support practice; addressing aboriginal problems and explicitly putting them on the agenda; strengthening gender-based analyses in practice; and improving mental health in the workplace.

One future opportunity stands out, and involves the urgency of addressing environmental health. Man-made climate change is drastically degrading our environments and as a consequence impacts our health. Canada ranks 14th in the world for carbon dioxide emissions, on a per capita basis. Canadian cities struggle with high levels of pollutants and periods of smog, exacerbating chronic conditions such as asthma and cardiovascular disease. Extreme temperatures lead to thousands of excess deaths every year. Increasing numbers of uncontrollable forest fires are destroying natural resources, wildlife, and emitting polluting particles into our environments. Health promotion practice can play a critical

role in directing Canadian citizens, organizations and decision-makers in improving our environment and our health. For example, it can increase awareness of the detrimental effects of environmental degradation on health outcomes; push for better urban design to encourage active transportation and community gardens; and foster the development of environmentally friendly policies that promote health and well-being. Pederson mentioned that this focus area will be the work of the next generation, and it will be what we will have to do to save the human species.

This work, though, will not happen without strong participation by youth. Engaging youth in health promotion has also been flagged many times as an opportunity and a challenge for the future of the field. To successfully engage youth, practice will need to redefine its perception of wisdom and knowledge. "We need to get out of the mindset 'age, experience, degrees, certificates equals knowledge'," says Norman. "There is so much experience and so much wisdom from someone who has been in the field for 30 years, but the fact is that there is an ability for young professionals to come in and teach older professionals, and for older professionals to teach younger professionals. I think every mentorship relationship needs to have a two-way arrow of learning. We talk about that but we don't actually do it very well in practice."

Indeed, North American millennials are among the most educated and ethnically diverse generation in the workforce to date. Thanks to health promotion efforts of previous generations, they were raised with recycling and climate change concepts. They grew up with advanced technology, and in an overwhelming number of cases, are the ones developing it. Given the growing prevalence of health promotion language and concepts across sectors, millennials have a unique perspective that can be extremely valuable for advancing the field of health promotion. The millennials have the opportunity to build upon the work of the practitioners who laid the foundations of health promotion, and to take the field further than it has gone before.

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The Ottawa Charter and the United Nations Sustainable Development Goals

How closely linked are the Charter's 5 strategies to the SDGs?

By Jean-Pierre Girard

It is widely recognized that the First International Conference on Health Promotion (HP), which took place in Ottawa in November 1986, and its main output, the Ottawa Charter for Health Promotion (OCHP), form a milestone in the history of HP. This achievement had historic roots; it did not spring out of nowhere. It was shaped by previous international events or declarations, like the Alma-Ata Declaration (1978), the WHO Resolution on *Health for All by the Year 2000* (1979), and by the resultant transformation of what had been called "health education" into "health promotion."[1] Based on international consensus, this Charter has been recognized as a cornerstone of health promotion.[2] In this sense, it also has been a springboard, introducing a new series of Global Conferences on HP. The ninth in the series will be held in Shanghai on November 21-24, 2016. Moreover, the OCHP's five basic strategies inspire not only to the health agenda but to other major international issues, like climate change. Those five strategies are:

- Build healthy public policy
- Create supportive environments
- Strengthen Community Action
- Develop Personal Skills
- Reorient Health Services[3]

[1] O'Neil et al. 2006.

[2] Potvin and Jones 2011.

[3] World Health Organization. "The Ottawa Charter for Health Promotion ... 21 November 1986." Geneva: World Health Organization. Retrieved September 13, 2016 (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index1.html).

The Charter and these five strategies embody a new understanding or vision of health, a matter worthy of more detailed exploration. For instance, according to the OCHP, the state of the environment, both natural and built, is as important to individuals' health as health education; these environments should promote rather than hinder individual change.[4] The notion of environment refers to *patterns of life, work and leisure* and also encompasses the idea of a *socioecological approach to health* – concepts that will evolve over time and gain in popularity and recognition. At the very centre of the strategy to "strengthen community action" we find the idea of empowerment: *At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.* For some authors, empowerment is what distinguishes HP from other public health functions. Indeed, in their view, empowerment is the essential meaning of HP.[5]

The Bangkok Charter (2005), in addition to reaffirming the link with OCHP, emphasized Non-Governmental Organizations (NGOs) and the role of civil society, two key concepts widely recognized since that time. We can also see the connection between the OCHP's description of "community action" and "civil society," even if the definition of the latter con-

[4] Parent 2016.

[5] Hyppolite and O'Neil 2003; Riddle et al. 2007.

cept is subject to debate. (People are more able to agree on what "civil society" is not – it is not the State, markets, Church and military – than what "civil society" is.[6])

Intrinsic to some of these concepts is a close linkage with the social determinants of health, i.e., how social inequality impacts health.[7] As explained in greater detail later in this study, they reveal the direct link between the Ottawa Charter and the Final Report of the World Health Organization Commission on Social Determinants of Health (2008): *Closing the gap in a generation: Health equity through action on the social determinants of health.*

The 2030 Agenda for Sustainable Development (specifically, the Sustainable Development Goals, or SDGs),[8] was adopted at the United Nations (UN) Sustainable Development Summit in New York on September 25, 2015, building on the Millennium Development Goals, which were in force 2000-2015. Like its precursor, the 2030 Agenda has a time horizon of 15 years. But once again the goals are ambitious, focusing on fighting extreme poverty and climate change but with great attention to health issues.

Is it possible to identify links between the Ottawa Charter of 1986 and the SDGs of 2015?

For such an appreciation, one would have to scan the Agenda carefully. Of course, such a reading would be subjective. In order to confirm the roots of the SDGs, one might study all previous international declarations in various areas, and from several sources in addition to the UN, for instance, the International Labor Organization, the World Bank, and the WHO. This is not the purpose of this paper.

How then to identify possible relationships between the Ottawa Charter and the SDGs?

To begin, let us select some passages from the SDGs which reflect, directly or indirectly, the strategies and principles of the Ottawa Charter.

> **Preamble**
>
> This Agenda is a plan of action for people, planet and prosperity. It also seeks to strengthen universal peace in larger freedom. We recognize that eradicating poverty in all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development. All countries and all stakeholders, acting in collaborative partnership […]

In the Preamble, the connection is clear between fighting (extreme) poverty and sustainable development. It reminds us of the importance of the 2008 report on the social determinants of health and their roots within the OCHP. This also is an appeal to all stakeholders to work in a collaborative partnership –another reflection of OCHP strategies.

Let us turn now to the Declaration:

> 2. On behalf of the peoples we serve, we have adopted a historic decision on a comprehensive, far-reaching and people-centred set of universal and transformative Goals and targets. We commit ourselves to working tirelessly for the full implementation of this Agenda by 2030. We recognize that eradicating poverty in

[6] Pirotte 2007. This concept of civil society is detailed in other sections of this report.

[7] Abel 2007. This notion of the link between equality and health has been very well documented in the bestseller of Richard Wilkinson and Kate Pickett, *The Spirit Level: Why Equality is Better for Everyone* (New York: Bloomsbury, 2009).

[8] United Nations. "Transforming our world: the 2030 Agenda for Sustainable Development." New York: United Nations. Retrieved September 12, 2016 (https://sustainabledevelopment.un.org/post2015/transformingourworld).

all its forms and dimensions, including extreme poverty, is the greatest global challenge and an indispensable requirement for sustainable development. We are committed to achieving sustainable development in its three dimensions – economic, social and environmental – in a balanced and integrated manner. We will also build upon the achievements of the Millennium Development Goals and seek to address their unfinished business.

Likewise, the OCHP aims to reach individuals as best as possible. It is a mix of action at the environmental and community level (Create Supportive Environments, Strengthen Community Actions) and at the individual level (Develop Personal Skills).

6. The Goals and targets are the result of over two years of intensive public consultation and engagement with civil society and other stakeholders around the world, which paid particular attention to the voices of the poorest and most vulnerable. This consultation included valuable work done by the General Assembly Open Working Group on Sustainable Development Goals and by the United Nations, whose Secretary-General provided a synthesis report in December 2014. […]

Many stakeholders attended the Ottawa Conference in 1986. At that time, Information Technologies (IT) were not so sophisticated as we have today (email, internet, social media). But the intent was to reach out not only to official representatives of health systems, but to other stakeholders, like NGOs. The purpose also was to hear the voices of low-income countries, whether their representatives were public agencies or NGOs.

Our vision

7. In these Goals and targets, we are setting out a supremely ambitious and transformational vision. We envisage a world free of poverty, hunger, disease and want, where all life can thrive. We envisage a world free of fear and violence. A world with universal literacy. A world with equitable and universal access to quality education at all levels, to health care and social protection, where physical, mental and social well-being are assured. […]

The vision expressed in point 7 above is very similar to the prerequisites for health identified in the OCHP: peace, food, education, income, etc.

16. Almost fifteen years ago, the Millennium Development Goals were agreed. These provided an important framework for development and significant progress has been made in a number of areas. But the progress has been uneven, particularly in Africa, least developed countries, landlocked developing countries, and small island developing States, and some of the MDGs remain off-track, in particular those related to maternal, newborn and child health and to reproductive health. We recommit ourselves to the full realization of all the MDGs, including the off-track MDGs, in particular by providing focussed and scaled-up assistance to least developed countries and other countries in special situations, in line with relevant support programmes. The new Agenda builds on the Millennium Development Goals and seeks to complete what these did not achieve, particularly in reaching the most vulnerable. […]

Uncompromising, this section clearly recognizes the unfinished business of the MDGs, *in particular those related to maternal, newborn and child health and to reproductive health.* Some NGOs and other NPOs that became involved in HP following the OCHP (with its strong focus on women's needs) also made this an area of activity.

20. Realizing gender equality and the empowerment of women and girls will make a crucial contribution to progress across all the Goals and targets.

The OCHP reaffirms the importance of equality between men and women in the paragraph entitled "Enable": *People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.* The SDGs also use the key concept of empowerment, as the means to "strengthen community actions."

> 26. To promote physical and mental health and well-being, and to extend life expectancy for all, we must achieve universal health coverage and access to quality health care. No one must be left behind. We commit to accelerating the progress made to date in reducing newborn, child and maternal mortality by ending all such preventable deaths before 2030. We are committed to ensuring universal access to sexual and reproductive health-care services, including for family planning, information and education. We will equally accelerate the pace of progress made in fighting malaria, HIV/AIDS, tuberculosis, hepatitis, Ebola and other communicable diseases and epidemics, including by addressing growing anti-microbial resistance and the problem of unattended diseases affecting developing countries. We are committed to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development.
>
> **SDG Goal 3. Ensure healthy lives and promote well-being for all at all ages**
>
> 3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

Point 26 and Goal 3 of the SDGs, especially item 3.4, are the ones which reflect the OCHP the most, but to a very specific purpose: the promotion of mental health and well-being. They are seen as one of two ways to reduce premature mortality from non-communicable diseases (NCD), the second being prevention and treatment. This link to NCD may be the key point of connection between the OCHP and the SDG, not only in terms of principles or values, but from a very practical perspective.

In this sense, it behooves every organization involved in HP, from local to international, public organizations, NGOs, and all the others, not only to carry on this work but to scale up their contribution to achieving this target and sharing the results: in other words, to gauge how their actions and their programs serve to reduce premature mortality from non-communicable diseases. In addition, in accordance with the OCHP strategies, simultaneous action is required, at the community and personal level, to build supportive environments and, moreover, to promote empowerment – the very heart of the strategy.

Such action makes more sense if it is undertaken collaboratively, for example, by developing a partnership with another organization, based on trust and transparency. The use of the social media would be highly instrumental in this regard.

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Charlottetown, Prince Edward Island

Civil Society's Role in Health Promotion: Some Essential Points of Reference

By Jean-Pierre Girard

The 2005 Bangkok Charter on Health Promotion (BCHP) makes specific reference to civil society and formally recognizes its connection to health promotion.[1] Commitment 3 of the BCHP identifies the promotion of health as a key focus of communities and civil society. The idea is that civil societies, or locally-engaged civil society organizations (CSOs) and non-governmental organizations (NGOs), can act as a bridge, bringing global health strategy into local action.

But what do we mean by "civil society"? It's a question with no easy answer. Although the term is widely used today, people's understanding of it varies. In fact, they agree more readily about what civil society is not – it is not the State, markets, Church or military – than about what civil society is.[2] Therefore, a quick exploration of the roots of the concept would help to clarify its contemporary meaning.

An Overview of the Historical Origins of Civil Society

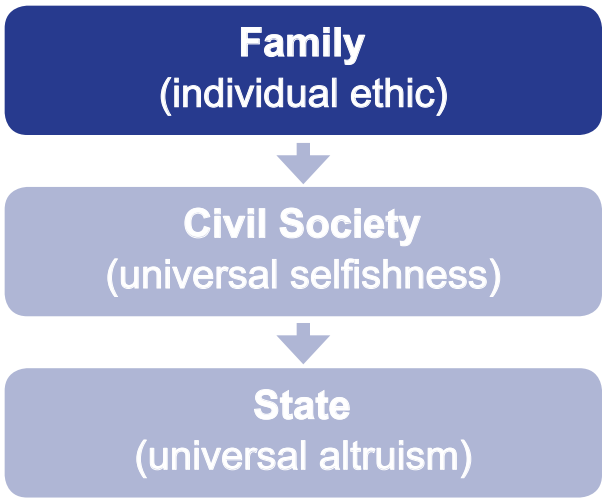
In Greece's Classical Period (480-323 BCE), the idea of citizen participation in the life of the City gained in popularity and came to be seen as a new form of government, democracy (*demokratia*[3]), "replacing the rule of hereditary kings and *archons* with that of an assembly of free citizens."[4] In the view of Aristotle, civil society (*koinōnia politiukē*) was a group of politically-organized citizens who were the cornerstone of the democracy. But civil society was not open to all citizens; it excluded women, slaves and foreigners.[5] This group of citizens, also called the Council or *Boule*, "are selected by lot to hold office one year, and a man can only be a councillor twice in a lifetime."[6] The proceedings of civil society took place in a public area (*agora*[7]).This ensured that every citizen could see and understand the discussion without impediment, hear various points of view and the arguments in support of each. In some ways, it is a kind of direct democracy, one that required a frequent turnover in its leadership. Power couldn't stay in the hands of one person, whatever his political skill or ability as a communicator.

In the Middle Ages (5th -14th Century CE), the notion of civil society was embedded in the idea of the Christian community. Belief in the will of God dominated, as did the role played by clergy or the church in linking humanity with God.[8] In this sense, civil society in this period was not an autonomous structure: it lacked the capacity to live outside the boundaries of the Church.

[1] World Health Organization. 2005. "The Bangkok Charter for Health Promotion in a Globalized World." Geneva: World Health Organization. Retrieved September 19, 2016 (http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/).
[2] Pirotte 2007.
[3] This term is made up of the two words *demos* (the people) and *kratos* (power). Chaline 2008, p. 18.
[4] Chaline 2008, p. 14.
[5] Pirotte 2007, p. 7.
[6] Chaline 2008, p. 19.
[7] In fact, the *Agora*, is the political and commercial hub of the city, the nucleus of the Athenian democracy is the *Bouleterion*. Chaline 2008, p. 66.
[8] Baubérot 2013, p. 7.

The ideas of such 16th-Century reformers as Calvin, Luther and Zwingli tended to decrease the influence of the clergy and instead link individuals with God face to face, without need of any intermediary (the Church). They also served to undermine the idea of the passive submission of the individual, current in the Roman Catholic Church of this time.[9] Protestantism promoted the free will of the individual, who could contract and act in association with others under strong collective discipline. Our idea of civil society also owes much to thinkers in the Renaissance (14th -17th Centuries, meaning literally "rebirth"), the period in European civilization immediately following the Middle Ages, and still more to the Age of Enlightenment[10] (18th Century), with its promotion of individual liberty and religious tolerance. What did "civil society" mean at that time? In a nutshell, for Hobbes and Locke, two renowned social contract theorists, civil society was very similar to political society. To them, civil society was a political union based on an implicit consensual arrangement.[11] The real distinction between the two terms and the basis of our modern understanding of civil society came later, with various 19th-Century contributions, especially those of Hegel (1821).

In the view of this German philosopher, the ethical life or social ethic (what he calls *Sittlichkeit* in German) was a cake with three layers.[12]



So, Hegel conceived of civil society as a kind of intermediary form between family and State. His clear distinction between the political realm or State and the family has heavily influenced the modern understanding of civil society.

Also in the 19th Century, using the same distinction between civil society and political society, the French political scientist, diplomat and historian, Alexis de Tocqueville, studied what America and Western societies were doing to improve the living standards and social conditions of individuals, including their relationship with the market and the State.

In the process, he discovered town hall meetings in America, where citizens took an active role in decision-making. He reflected on this in his *Democracy in America* (1835-1840),[13] a book whose influence on today's vision of civil society is hard to underestimate.[14] De Tocqueville observed how American citizens gathered in associations for a wide range of activities, like founding a hospital, building a church, or organizing a celebration. He

[9] Baubérot 2013, p. 39.
[10] In French, *le siècle des lumières* and in German, *Aufklärung*.
[11] DeWiel, Boris 1997. "A Conceptual History of Civil Society: From Greek Beginnings to the End of Marx." *Past Imperfect* 6:3-42. Retrieved September 19, 2016 (https://ejournals.library.ualberta.ca/index.php/pi/article/viewFile/1422/963).
[12] Based on Pirotte 2007, p. 25. This explanation of civil society was developed by Hegel in his book *Grundlinien der Philosophie des Rechts.* (In English: *Elements of the Philosophy of Right*.)
[13] In fact, the original one was in French: *De la démocratie en Amérique.*
[14] Pirotte 2007, p. 12.

found *in the existence of a dense association network one of the conditions to the emancipation of true democracy capable of combining equalization of social conditions and respect for individual freedoms.*[15] In his view, America differed entirely from France at that time, where such activities were under the hand of government, or in the case of the UK, required the leadership of the lordly.

The Civil Society Today

More recently, "civil society" in some countries refers to the Third Sector, meaning various organizations that offer services and solidarity and, while different from State and market, are connected to both. Elsewhere it takes the name of "social economy," with clear reference to the governance or the democratic life of such organizations, such as associations, cooperatives and mutuals. This is not the case in Anglo-Saxon countries. There, as the work of Salamon and Anheier[16] indicates, people talk instead about a "nonprofit sector," which encompasses nonprofit organizations (NPOs). So the nonprofit dimension becomes key. To one of the most influential sociologists of recent years, Jurgen Habermas, civil society is based on networks of association that offer public space for conversation in order to solve problems of general interest.[17]

For practical purposes, consider the following definition of civil society developed by a number of leading research centres and adopted by the World Bank:

> *… the term civil society [refers] to the wide array of non-governmental and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on cultural, ethical, political, scientific, religious or philanthropic considerations. Civil Society Organizations (CSOs) therefore refer to a wide of array of organizations: community groups, non-governmental organizations (NGOs), labor unions, indigenous groups, charitable organizations, faith-based organizations, professional associations, and foundations.*[18]

Civil Society and the Health Issue

Civil society is well placed to connect global health strategies with local action, and the Bangkok Charter on Health Promotion thus recognizes how community organizations, CSOs and women's collectives have demonstrated their effectiveness in health promotion and programs, and should serve as inspiration to others.[19]

Addressing the question of globalization and health, Loewenson (2003)[20] quotes various authors regarding the positive role of CSOs, including their importance as a countervailing power to markets:

> *Civil society is argued to be a force for more humane governance and more human-centred development and thus a counter to powerful private for profit interests within current*

[15] Pirotte 2007, p. 23.
[16] Salamon and Anheier 1998.
[17] Habermas 1997, p. 394.

[18] The World Bank. "Defining Civil Society." Washington, D.C.: The World Bank. Retrieved September 19, 2016 (http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/CSO/0,,contentMDK:20101499~menuPK:244752~pagePK:220503~piPK:220476~theSitePK:228717,00.html).
[19] World Health Organization. 2005. "The Bangkok Charter for Health Promotion in a Globalized World." Geneva: World Health Organization. Retrieved September 19, 2016 (http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/).
[20] Loewenson, R. 2003. "Civil society influence on global health policy." In *Annotated Bibliography on Civil Society And Health*. Harare, Zimbabwe: World Health Organization Training and Research Support Centre. Retrieved September 19, 2016 (http://www.tarsc.org/sites/default/files/uploads/pdf/WHOTARSC4.pdf).

processes of globalization. CSOs are argued to reinforce the public interest roles of states and balance the growing influence of markets (Edwards undated; Dodgson, Lee and Drager 2002; Labonte 1998).

In terms of areas of intervention, again from the perspective of global health, Loewenson writes:

CSOs have intervened in global health policy in a number of ways. These include interventions to legitimize policies, mobilize constituencies, resources and actions around policies and to monitor their implementation. CSOs have contributed technical expertise to policy development. They have made global and international policy processes more publicly accessible through disseminating information on them, and thus helped to widen public accountability around these policies (Turmen 1999; Sheehan 2000).

But what are the impacts of CSOs?

UN agencies have reported benefits from CSO engagement and alliances in terms of community support of new initiatives, shared values, knowledge and expertise, increased resource mobilisation and increased policy accountability (Gates Foundation 2001; Haines 1997; Nelson 2002; Ibrahim 1998). This gain from CSO involvement in policy processes is reported in the literature to derive from CSOs contributing skills, leadership and constituencies to back policy changes and disseminating social innovation.

Challenges for Today's CSOs

Over the last decades, no one can underestimate the crucial role of CSOs in the promotion of an international agenda in regard to feminism, the environment (climate change) or the rights of the person (for instance, Amnesty International). This is also true for issues of health promotion, like the work of the Alliance for Health Promotion or the International Union for Health Promotion and Education.

Today more than ever, in this age of social media and the Internet, CSOs can develop and nurture links very efficiently and extremely quickly, based on a "just-in-time" approach. The impact of such tools as Facebook or Twitter is so great that in some countries, the State simply blocks access to this content, due to the threat it may pose to their policies. All of us remember the boost which the Arab Spring received from such media.

But social media by themselves are no guarantors of efficiency on the part of CSOs. Depending on how they are used, and in the absence certain terms and conditions, CSOs can be closed to outside influences, in the worst case, becoming secret organizations. The Ku Klux Klan is one example. This is why the way in which CSOs are lead or operate is so important. To Habermas, in order to be a true expression of democracy, civil society must be a place that promotes deliberation and arguments. Like John Rawls,[21] Habermas develops the concept of "deliberative democracy," in which the decision-making process takes contributions from various points of view, and, at the end, arrives at a decision based on the best arguments. Deliberative democracy rests on three principles:

- The importance of argument: the decision must be the result of exchange and discussion of various points of view.
- Inclusion: The discussion must be open to all stakeholders who are concerned or will be impacted by the decision.

[21] Rawls 1971, 1997.

- Transparency: The discussion and the decision must occur publicly. There is no hidden process.

Within the context of deliberative democracy, CSOs become key actors in a new and refreshing democratic process, including the idea of slow democracy.[22]

At the very heart of CSOs there is a relationship among individuals, or more simply, a social relationship. Some authors, like Robert Putnam in his best-seller *Bowling Alone: The Collapse and Revival of American Community,* prefer to use the term "social capital." For Jeremy Rifkin, in his famous *The Third Industrial Revolution*, civil society is the place where humanity creates social capital. At some level, what both these scholars are talking about is trust, another operating principle of the CSO.[23] Trust is the lubricant in the relationship between CSO stakeholders.

In the understanding of DeWiel (1997),[24] while civil society must be autonomous from the State, it also is based on interdependence and on pluralism in values, ideals and ways of life.

Of course, we must not underestimate the importance of governance to CSOs. Just as good corporate governance is essential to for-profit enterprise (FPE), so CSOs must attach high priority to their own model of governance. How do we implement mechanisms of accountability? How can CSOs *accomplish their social missions effectively, efficiently and responsibly?*[25]

CSOs also have a remarkable capacity to bring diverse stakeholders under a common umbrella. They may be individuals, corporations and sometimes representatives of public bodies. As the French sociologist Jean-Louis Laville has shown,[26] this is an organizational framework that welcomes resource hybridization. That means, a mix of income streams, including agreements with public authorities, donations, market sales of products or services and voluntary contributions. This is totally different from FPEs, where income derives only from market relationships and services are supplied only by paid staff.

As a last point, over the past decade, as Harvard University professor Yochai Benkler[27] notes, hundreds of studies conducted across dozens of cultures have found that most people will act far more cooperatively than previously believed. This is a major discovery, offering a brand new understanding of humanity: we are not universally and inherently selfish creatures! In the context of their social missions, many CSOs welcome voluntary contributions in addition to paid staff, or simply operate on the basis of a set amount of volunteer hours. In other words, CSOs are a fabulous framework for the expression of collaboration and co-operation among a wide array of stakeholders, including volunteers!

[22] "Slow Democracy … is an invitation to bring the advantages of 'slow' to our community decision making. Paralleling slow food's push for authenticity in what we eat, slow democracy calls for first-hand knowledge of the local decisions that matter to us. Just as slow food encourages chefs and eaters to become more intimately involved with the production of local food, slow democracy encourages us to govern ourselves locally with processes that are inclusive, deliberative, and citizen powered." Clark, S., and W. Teachout 2012, p. xxii.
[23] Pirotte 2007, p. 47.
[24] DeWiel 1997.
[25] Herzlinger 1999, p.1.
[26] Laville 2013.
[27] Benkler 2011.

For Benkler, the availability of a tool like the Internet boosts this capacity:

> *The emergence of social production on the Internet has given us countless newer, cheaper, easier, and more rewarding platforms for collaboration than we have ever had before. On the web, people are engaging in voluntary acts of cooperation every day …. And increasingly we see software developers, entrepreneurs, and civil society organizations experimenting with and building online systems of social, cooperative interaction—with amazing results.*[28]

Within the foregoing, the points of congruence between health promotion and CSOs are inescapable: they share such key notions as empowerment, open-mindedness to diverse stakeholders, the importance of nurturing social relationship, and the conviction that citizens can play an active role in health promotion. Social media and its capacity to facilitate collaboration and cooperative interaction could be instrumental in this undertaking.

In summary, within certain parameters, the engagement of CSOs in health promotion has a bright future!

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[28] Benkler 2011, pp. 23-24.

The Circle of Health

A practical application of the Ottawa Charter, bringing a holistic & systematic approach to health promotion research, education & practice

"Stay at the center of the circle and let all things take their course." Confucius

By Patsy Beattie-Huggan

Abstract

The Circle of Health is an innovative health promotion framework and tool that was developed in 1996 through a community development process in Prince Edward Island (PEI), Canada's smallest province. The Circle of Health offers a valuable visual synthesis of key health theory and policy documents that has the flexibility to be applied to the specific issues and concerns of each particular context for multiple purposes, such as education, partnership development or planning.

While developed and validated to meet local needs, this framework has had national and international uptake, and continues to be used and celebrated by users for its unique contribution to health promotion practice. Since its development, the Circle of Health has traveled beyond the boundaries of its intended application. It is in use in over 20 countries and available in six languages – English, French, Spanish, Portuguese, Serbian and German. The Circle of Health has appeal because it can be used by many cultures and learning styles: to work with individuals and population aggregates; to address the determinants of health; to empower users to embrace evidence; to value intuition and wisdom as important sources of knowledge; and to focus on all aspects of health – spiritual, physical, mental and emotional. Subject to great scrutiny through evaluation, the Circle of Health is uniquely positioned amongst frameworks discussed in the literature.[1]

This paper presents a description of the Circle of Health, and the factors that have contributed its development and uptake. It is presented with the understanding that today more than ever, people are searching for ways to feel a sense of connection in their lives and incorporate values in decision-making.

Introduction

The Circle of Health provides an "at a glance" view of what we currently know about creating health. Each ring of the Circle of Health represents a body of knowledge.[2] The orange ring represents holistic health (spiritual, physical, emotional, mental); the yellow ring the Ottawa Charter; the blue ring represents determinants of health/population health; the green ring outlines population groups as referenced in social theory; and the purple ring includes values and ethics in our society. The Circle of Health can be entered at any point and is

[1] Beattie-Huggan and Mitchell. 2005. "The Circle of Health©: A Health Promotion Framework of International Interest for Education, Policy and Practice". Unpublished manuscript.
[2] PEI Health and Community Services Agency. 2003. "Circle of Health: Prince Edward Island's health promotion framework." Charlottetown, PEI: The Quaich Inc.

moveable. As one addresses each element in the outer rings, one moves toward the center, where there is integration and wholeness – a goal of balance **for the individual, family, community, system or society.**[3]

Figure 1. The Circle of Health (revised version based on validation feedback).

Copyright © Prince Edward Island Department of Health and Community Services Agency 1996

The tool provides visual cues to the five levels of theory and practice. With facilitation, it will support users to think broadly, collaboratively, holistically and systemically, while attending to both values and the broader determinants of health. In the Circle of Health, the concept of health is positive and is defined as a "resource for everyday living,"[4] while health promotion is defined as the "process that enables people to take control over their health."

A unique feature is that it enables a determinants approach to be applied when working with populations and individuals. The Circle of Health requires the engagement of users and leads to empowerment – a key outcome of health promotion.[5]

The Circle of Health provides an important contribution to the field of health promotion as it is an accessible, plain language tool that reflects a broad definition of health and therefore can be used by individuals, community organizations, academics and health professionals in diverse settings. It uniquely incorporates health promotion and population health theories and Aboriginal concepts of wholeness (with attention to the mind, emotions, body and spirit), as well as the principles of caring and justice.

In 1996, when there was only an initial awareness that a gap existed between knowledge development and its use, and that knowledge should be produced in forms that are more useable and user-friendly,[6] the PEI Health Promotion Framework broke new ground. It demonstrated that involving stakeholders in development and evaluation results in clarity of language, design and creativity and encourages knowledge development and translation.[7] The Circle of Health was influenced by the work that preceded it and the context in which it was developed.

[3] The Quaich Inc. 2011. *Circle of health facilitator's handbook: Knowledge, application, skills.* Charlottetown, PEI: The Quaich Inc.

[4] World Health Organization Regional Office for Europe. 1986. "Ottawa Charter for Health Promotion." Copenhagen. Retrieved September 12, 2016 (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/).

[5] The Quaich Inc. 2011. *Circle of health facilitator's handbook: Knowledge, application, skills.* Charlottetown, PEI: The Quaich Inc.

[6] Green, L. 1996. "Bringing people back into health." *Promotion and Education* 111; 23-26.

[7] Beattie-Huggan, P. 1996. "Use of conceptual models in organizational change; the experience of Prince Edward Island." Presentation UPEI Health Promotion Summer Institute.

Contributing Factors

Context

In the early 1990's, policy makers in PEI embarked on a new policy direction based on a population health approach. It embraced principles of health promotion and primary health care as set out by the World Health Organization (WHO)[8] and adopted a philosophy of health promotion. A restructured health system brought together disciplines within and outside of the health system including public health, hospital settings, social services, housing and justice. As a result, diverse understandings and expectations of health promotion arose, which made it difficult to prioritize and decide on resources. Planners saw value in adopting a conceptual framework to communicate a shared understanding of health promotion and coordinate health promotion work in the system and community. The Circle of Health[9] (Copyright © Prince Edward Island Health and Community Services Agency 1996) framework emerged to meet this need.

Process of Development

The Circle of Health was developed through a partnership of health system, community and academic participants using principles of adult education and qualitative research in a two-day gathering of 80 people. It was validated later through five focus groups and consultations. During this process participants confirmed the need for and purpose of a framework for PEI and determined the content. Of particular influence was the conceptual linking of Bhatti and Hamilton's *Population Health Promotion Model*.[10] Evans and Stoddart[11] noted how it warranted special attention for linking population health research with health promotion activities. However, in keeping with the principles upon which it was developed (community development, adult education, and qualitative research), the Circle of Health evolved beyond this work. As a result, the Circle of Health brings together and extends the approaches taken in existing models. It reclaims ancient wisdom and holism in the form of the circle and the inclusion of the Aboriginal Medicine Wheel, and integrates values as a foundation for creating and sustaining health in communities, families and organizations. While the health system structure of the time no longer exists, the Circle of Health continues to resonate with users and attract interest. Developers of the Circle of Health attribute its creation and unanticipated uptake to the integration of theory and practice, the discussion of vision and values, shared leadership, and respectful attitudes, indicative of both the context and the creativity of its development.

Valuing Spiritual Health & Connection

The decision to link the concepts in a circle proved to be significant. Circles are ancient

8 World Health Organization Regional Office for Europe. 1978. "Declaration of Alma-Ata." Copenhagen: World Health Organization. Retrieved September 12, 2016 (http://www.who.int/publications/almaata_declaration_en.pdf).

9 PEI Health and Community Services Agency. 2003. "Circle of Health: Prince Edward Island's health promotion framework." Charlottetown, PEI: The Quaich Inc.

[10] Hamilton, N., and T. Bhatti. 1996. "Population health promotion: an integrated model of population health and health promotion." Ottawa: Health Promotion and Development Division, Health Canada. Retrieved September 12, 2016 (http://www.phac-aspc.gc.ca/ph-sp/php-psp/index-eng.php).

[11] Evans, R.G., and G.L. Stoddart. 2003. "Consuming research, producing policy?" *American Journal of Public Health* 93:371-379.

symbols in all parts of the world that reflect universal understanding. In Aboriginal cultures the four directions of the Medicine Wheel symbolize the qualities of the whole (for example, illumination, renewal, assimilation and wisdom).[12] In Britain, circles of standing stones such as Stonehenge were centers of knowledge and wholeness, linking time and place to earth, the universe and spiritual knowledge.

The Circle of Health visually makes a bridge between ancient wisdom inherent in the Aboriginal Medicine Wheel, Eastern philosophies, Celtic knowledge and current Western knowledge about health and health promotion. For some the Circle of Health is a Medicine Wheel. For others, it is a mandala whose coloured rings align with colours associated with the chakras.[13] As a result, the Circle of Health appeals to many cultures and encourages cross-cultural and intersectoral work – and validates the inclusion of spiritual health in conversations about health.

Importance of Facilitation & Resources

Evaluations of the Circle of Health have stressed the importance of facilitation to make the links between practical and conceptual thinking.[14] With skilled facilitation, the Circle of Health can be used with a variety of people in limitless contexts. A balanced, holistic facilitator will help to guide others toward balance and wholeness. "The means is the end" and *how* we facilitate a process determines the end result. In other words, it is the process, the journey to the end that is shaped by facilitation.

A facilitator who takes time to experience physical, mental, emotional and spiritual dimensions will support balance in the role of facilitating. The plain language *Circle of Health Learning Guide* and practical examples can help the facilitator to expand and adapt the use of the Circle of Health to many audiences. To assist facilitators, a *Circle of Health Facilitator's Handbook* was developed in 2011 and a website with products, stories and resources developed the same year.

> *Connecting ancient mystery, current research, personal experience and evolving knowledge leads the facilitator to creativity with the Circle of Health.*

Conclusion

According to Berg and Sarvimaki[15] even in multidimensional views of health the spiritual component is often missing. By incorporating the Medicine Wheel, the Circle of Health includes all dimensions of health and compels users to take action towards creating balance in the lives of individuals and communities. Dr. Terry Mitchell has stated that the congruency of the process of development and the content of the Circle of Health strengthens its links to theory. The hunger in today's society for the authentic may well be what attracts users emotionally and spiritually to the Circle of Health.

[12] Nelson, Annabelle. 1994. *The Learning Wheel: Ideas and Activities for Multicultural and Holistic Lesson Planning*. Tucson, AZ: Zephyr Press, as referenced in Facilitator's Handbook (The Quaich, 2011).

[13] "Mandala: any of various geometric designs (usually circular) symbolizing the universe; used chiefly in Hinduism and Buddhism as an aid to meditation." Princeton University. "WordNet Search – 3.1." Retrieved September 12, 2016 (http://wordnetweb.princeton.edu/perl/webwn?s=mandala).

[14] Smith, N. ed. 2000. "Sharing the circle- telling the story: an online conference, volume 2." Halifax, NS: The Atlantic Centre for the Study of Human Health.

[15] Berg, G.V., and A. Sarvimaki. 2003. "A holistic-existential approach to health promotion." *Scandinavian Journal of Caring Sciences* 17(4): 384-391.

Circles are especially useful for complex issues, like many of the interconnected factors of health and well-being present today. Many situations are multi-layered and a model such as the Circle of Health can address the complex web of connections. While developed for health promotion, the Circle of Health is readily adaptable to justice, economic, business and environmental issues, all of which contribute to individual, community and social well-being, and lends itself to all learning styles and education levels.

Applications of the Circle of Health are evolving, yet each ensures that health is viewed holistically, connections are made, planning is comprehensive, and decisions are based on values. The Circle of Health is packaged with the *Circle of Health Learning Guide*, and Health Promotion Background Document. These offer greater depth regarding the concepts embedded within the Circle of Health, history of health promotion, and the story of development of the Circle of Health. To assist more linear thinkers, colour-coded templates and resources have been developed to allow the circle explorations to be communicated in ways people can use and understand. These are available for free download online at www.circleofhealth.net. In-person workshops are also available in French and English.

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The *Hans Kai*

The implementation in Canada of a Japan's fascinating health promotion program

By Michelle Kirkbride

In 2007, Nancy Heinrichs, Executive Director of NorWest Co-op Community Health Centre (Winnipeg, Manitoba) and Nancie Allaire, Executive Director of Robert Cliche Co-op de Santé (Beauceville, Québec) participated in a co-op tour of Japan organized by Jean-Pierre Girard, an international expert in health co-operatives. They were able to observe the health co-ops in Japan's *Hans Kai* Program. Upon returning to Canada, Both Nancy and Nancie began to work together to develop *Hans Kai* for Canadians.

NorWest Co-op began work on *Hans Kai* in late 2009. This included a best practice search to look into programs similar to *Hans Kai* as well as setting up an inter-professional advisory committee of experts to help steer the project to implementation. The group developed an 8-session "health school" with the Robert Cliche Co-op de Santé. This ensured that the *Hans Kai* program in Canada was standardized.

Hans Kai is a participant-based health program for people wanting to maintain or improve their health. *Hans Kai* empowers individuals to take control of their own health. It provides a unique opportunity for participants to take an active role in improving or maintaining their own health and well-being and that of their community.

How it Works

NorWest works with interested community or workplace members to develop a *Hans Kai* training and ongoing program. Participants create small groups of 5-40 people.

All participants attend a free health series called Hans Health School where they learn about the *Hans Kai* program from health professionals. Eight sessions, each of 1-2 hours (workplace sessions last one hour, community sessions two hours), cover the following:

1. **Introduction to Hans Kai**: An introduction and goal-setting session, core activities, and general information about health and *Hans Kai*.
2. **Health Indicators**: a session that teaches participates how to safely and effectively monitor their own blood glucose, blood pressure and waist circumference.
3. **Eating For Health**: nutrition, healthy eating and food safety information.
4. **Let's Get Active**: types and benefits of exercise as well as developing physical activity plans for all abilities.
5. **Achieving Balance**: Participants learn about signs and symptoms of stress and how to manage it. In addition, participants learn about the importance of sleep and resources to support good sleep patterns.

6. **Primary Care through the Years**: General overview of health checks over time, medications and introduction to smoking cessation.
7. **Working Together**: community resources, boundaries and consensus decision-making, including how to work as a group.
8. **Launching the Hans Kai**: the identification of group resources and strengths, followed by a practice session to see how the group will function as an independent *Hans Kai* group.

After the health school, groups meet for a minimum of two hours per month for at least a year. Most groups meet weekly or bi-weekly for an average of 1.5 hours.

At *Hans Kai* meetings, group members conduct self-health checks, including blood pressure, blood glucose and waist circumference. They engage in physical activity, enjoy healthy snacks and have time to socialize. The group may also arrange presenters to talk about different recreational activities or health topics. NorWest furnishes internal and external resources to facilitate requests for presentations. Groups are self-directed with participants taking an active role in how their group runs. All decisions are made collectively by the group. Responsibilities are divided up based on group consensus. Health professionals are always available to support the group as needed.

Evaluation and Research

We hope that *Hans Kai* impact participants' long-term health in a positive manner. The goal of *Hans Kai* is to ensure participants improve their health and wellness, or maintain positive levels in each. In particular we focus on

- Nutrition: *Hans Kai* members are encouraged to eat healthy meals in accordance with the Canada Food Guide. *Hans Kai* should assist with improving nutrition.
- Physical Activity: *Hans Kai* promotes activity no matter what a person's level of mobility. *Hans Kai* should result in increased activity levels on the part of members.
- *Hans Kai* members should experience improvement in their blood pressures or sugars and maintain these levels.
- *Hans Kai* members should experience improved mental health or, if their results are already in the positive range, maintain these levels.
- *Hans Kai* members should feel more in control of their own health.
- *Hans Kai* members should experience improved social supports. The World Health Organization deems this factor as the most impactful health determinant.

Although our research report is still pending, observational data indicates that *Hans Kai* participants have created strong social supports, improved their activity levels and improved their eating habits.

Thanks to the Health Care Co-operatives Federation of Canada and their chair Vanessa Hammond, *Hans Kai* is available in many communities across Canada.

Currently a total of 155 people in Winnipeg are enrolled in *Hans Kai*. They are members of 12 *Hans Kai* groups. Ages range from 24-92; 75% of members are women and 25% are men.

Many different cultural groups are represented.

NorWest has trained 48 *Hans Kai* facilitators across Canada to deliver *Hans Kai* in their communities.

NorWest has launched a Hans program for youth aged 14-18 years. This summer NorWest offered its first family *Hans Kai* summer program for 5-12 year olds. These programs are standardized with Robert Cliche in Beauceville.

NorWest will continue to offer *Hans Kai*, Hans youth and the summer program in their community as well as provide training across the country. Once the research report on *Hans Kai* is complete, NorWest will share the results accordingly.

Health Promotion and the Value of Upstream Intervention

By Christine Morrison

Across the country, as the population grows and ages, health care costs, sustainability and the quality of care remain key issues for Canadians. Health promotion will play a critical role in achieving sustainability and delivering quality care to all Canadians.

"Health is more than health care," says Barb Willet, Executive Director at Health Nexus. "When viewed broadly, health promotion is about developing strategies to address the factors that impact on health but which lie outside of what is traditionally viewed as the health system – the broader determinants of health including education and income."

Health promotion goes beyond health education to enable individuals to increase control over and to improve their health.[1] Health promotion represents an "upstream" approach to addressing health care needs.

Furthermore, investing in health promotion and disease prevention makes good fiscal sense. Every dollar invested in promoting healthy eating and physical activity saves six dollars in the cost of caring for individuals with chronic disease.[2]

For more than 30 years Health Nexus has been a bilingual leader in health promotion that supports individuals, organizations and communities to build their capacity to implement health promotion strategies that address the underlying determinants of health and enhance community well-being.

Alone We Go Faster, But Together We Go Further

In recognition of the complexities that underlie today's health challenges, organizations are increasingly working together to address health needs.

"The challenge facing many organizations today is that while many have worked with partners in the past, few have experience in working as a true collaborative," says Ms. Willet. "That's where Health Nexus and our expertise comes in. We can help new groups come together, we can help existing groups evolve as a collective and we can help create plans to achieve agreed upon goals."

About a year and a half ago, Health Nexus was approached by Toronto Public Health for support in their efforts to bring together a wide range of organizations to transform the cultural norms surrounding breastfeeding within Toronto and build on their Baby Friendly Initiative (BFI) designation. The approach recognizes the challenge of shifting societal norms as well as the range of supports necessary in order to empower breastfeeding parents.

In their vision of the creation of a network, Toronto Public Health wanted ownership to reside within the group itself. Working with an

[1] Ottawa Charter for Health Promotion. 1984. Retrieved September 12, 2016 (http://www.who.int/healthpromotion/conferences/previous/ottawa/en/)

[2] Trust for America's Health. 2008. *Prevention for a Healthier America: Investments In Disease Prevention Yield Significant Savings, Stronger Communities*.

external partner, like Health Nexus through HC Link, helped to preserve this neutrality, provide a framework for beginning an effective partnership among an array of partners and build internal confidence and capacity.

Today, the *Toronto BFI/Breastfeeding Network* credits the work of HC Link in bringing the coalition together and creating a space to share breastfeeding-friendly initiatives across sectors.

Identifying Partners

"Recently, Health Nexus began an exciting Network Mapping program," says Ms. Willet. "What's unique about the network mapping process is it provides a visual baseline of current levels of interconnectivity within your community. This information can serve to identify new potential partnerships, and can also help gauge cross-sectoral penetration."

Within the field of health promotion is the recognition that no one person, no one agency and no one sector can effect meaningful change alone.

"I think every organization needs to ask themselves do they want to accomplish something quickly or do they want to create long term change," says Ms. Willet. "There is strength to working together and embracing our differences as we work to create true health equity."

About the author

Currently celebrating our 30th anniversary, Health Nexus is a bilingual leader in health promotion that supports individuals, organizations and communities to build their capacity to implement health promotion strategies that address the broad determinants of health and enhance community well-being.

The **Best Start Resource Centre** provides information and resources for health service providers and parents on a broad range of preconception, prenatal and child health promotion topics, including resources that promote breastfeeding and provide strategies to address the barriers to breastfeeding among populations with low breastfeeding rates. Through our Best Start Resource Centre, Health Nexus is recognized for its leadership role in championing breastfeeding and its lifelong benefits.

HC Link is a collaborative of three partner organizations that support community groups, organizations and partnerships in Ontario to build healthy communities. Health Nexus, Ontario Healthy Communities Coalition (OHCC), and Parent Action on Drugs (PAD) work together as one organization, capitalizing on the strengths of each partner to offer high-quality, coordinated services. HC Link provides a wide range of capacity-building services to those working on community-based health promotion programs and initiatives. HC Link has a proven track record in providing services that are not only responsive to client needs but also anticipate emerging trends and issues in the field.

Health Nexus has decades of experience in facilitating connections between healthcare stakeholders and collaborators across a range of sectors that impact underlying determinants of health.

Support Health Promotion in the Workplace

by Roger Bertrand

On the eve of the celebrations marking the 30th anniversary of the Ottawa Charter,[1] I'd like to answer a few questions that we're often asked about "Healthy Enterprise." What is it, exactly? Where did the initiative come from? Why a "Healthy Enterprise" standard? What is its connection with the Groupe entreprises en santé? Does it offer support? And so on...

These simple questions are most welcome. They demonstrate people's interest in the potential of business[2] when it comes to health promotion and prevention.

Where It All Began

From the start of the 1980s, as an economist and Director of Health and Social Programs at the Conseil du Trésor du Québec, it became obvious to me that the budget share of these health and social services expenditures would quickly turn into a real problem, given the evolution of the age pyramid, technology, and medical practice. Gradually, the healthcare system would bear the lion's share of total expenditures if we failed to stabilize (better still, to reverse) the trend.

And so it was that between 1985 and 1988, as a member of the Commission of Inquiry for Health and Social Services in Quebec (Rochon Commission), I and my fellow Commissioners were able to take a closer look at the operation and funding of this system, and then at possible solutions. One of these was the importance that should be accorded to the promotion of health and the prevention of disease, or "...concerted prevention strategies," as the Commission stated.[3]

This recurrent prescription, a consistent feature of Commission and committee reports focusing on these issues from the early 1970s to today, would guide me in my path: first within the health and social services network from 1989 to 1993; then into politics for the next ten years, including just over a year as the minister responsible (notably, and at my express request) for prevention, January 2002 to April 2003.

In the end it was too late to plunge directly to "health matters," which had been an important motivation for my entry into politics. Too little time to act. What happened next was simple: the government lost the general election in April 2003, and the transformation of promotion and prevention, to which I had dedicated myself for the past 13 years, was far from complete, or even under way. What to do?

And so that fall, it was suggested that I focus on the world of business– getting people interested in the benefits of preventing disease, and promoting health in that way, since it pays off in every respect. I did a quick assessment: it is a world in which most of the

[1] At the 1st International Conference on Health Promotion in Ottawa, a Charter was adopted on November 21, 1986. Its intention was to contribute to realizing the goal of "Health for All." According to the World Health Organization, the goal of health promotion is to give people more control over their own health and over the means of improving it.

[2] In this article, this term is used in the broadest sense, including public, quasi-public, and private organizations.

[3] *Rapport de la Commission d'enquête sur les services de santé et les services sociaux*. 1988. Les Publications du Québec. P. 456.

population lives and spends the majority of its waking hours, in a pre-organized environment (a "decisive factor," according to experts). Knowledge is there. Workers are often leaders there, and surely would have an impact on those around them, were they to adopt a healthier lifestyle. In short, let's make it the launch pad for a collective effort that benefits businesses, employees, the economy – and public finance (if indirectly we manage to reduce the pressure on health services).

The Emergence of Groupe entreprises en santé

With the support of key business leaders, the Groupe pour la promotion et la prévention en santé (GP^{2}S) was created, then became Groupe entreprises en santé (Groupe ES) in 2012. It is a non-profit organization that encourages businesses to establish a sustainable, structured, integrated approach which, based on best practices, targets overall health in the workplace, business competitiveness, and the vitality of the Quebec economy.

The Genesis of the Healthy Enterprise Standard

Groupe ES figures notably in the origin of a world first: the BNQ 9700-800 Standard – Prevention, Promotion and Organizational Practices Contributing to Health in the Workplace (2008).[4] It's a point of reference, informed by best practice. It invites businesses to take action in four spheres recognized for their positive impact on health in the work environment: employee lifestyle, work-life balance, workplace, and management practices.

Capitalizing on this important resource, Groupe ES encourages all businesses to initiate a structured approach, entitled "Healthy Enterprise," to integrate these practices as seamlessly as possible into their organization.[5]

To this end, we developed an extensive network of members and partners, as well as awareness and learning activities, and training[6] and support resources (reference materials, toolbox, provider directory, etc.). Groupe ES hosts an array of events, among them, since 2013, an annual gathering of over 1,000 people, many of them experts in the field.[7] We also regularly respond to requests from across Canada and France (where developments in Quebec are a matter of some interest). This outreach has led to productive partnerships.

More recently, Groupe ES has worked to boost the profile of psychological health among the significant challenges facing our organizations in terms of workplace health. At the same time we have been finalizing a solution tailored to small and medium-sized businesses.

What's the connection to the 30th anniversary of the Ottawa Charter?

The 6th Global Forum on Health Promotion takes place in 2016 – the 30th anniversary of

[4] This standard was developed by the Bureau de normalisation du Québec (BNQ) in accordance with a mandate to that effect entrusted to it by Groupe ES in 2006. The corresponding certification program, also developed by the BNQ, has been available since 2009.

[5] We know how to take positive action on health within an environment. When founding Groupe ES, the challenge was to find a way to integrate this knowledge in a way that was compatible with business operations. This gave rise to the idea for a corresponding standard. It's that simple!

[6] This training enables both employers and service suppliers to learn about best practices and success factors for implementing a structured approach to health in the workplace.

[7] For further details, go to Groupe enterprises en santé website, https://www.groupeentreprisesensante.com/fr/.

the Ottawa Charter, a fundamental document in modern public health. It's the perfect opportunity to tally up the progress made in this field to date and raise awareness of inspiring accomplishments, from the local to the international.

Under the motto "Health Promotion ~ At the Very Heart of Sustainable Development," a new study of best practices in global health promotion will spotlight salient initiatives in health promotion. Among them, the Healthy Enterprise Standard has gained increasing international recognition for its positive impact on business productivity, quality of working life, the economy, and, of course, health.

Conclusion

By Jean-Pierre Girard

There's no question about it. In the 30 years since the adoption of the Ottawa Charter, skills and expertise in the realm of health promotion have grown in any number of ways: areas of intervention, approaches, stakeholders, partnerships – whether we're talking between civil society and government authorities, or fruitful collaborations between practitioners and the world of academic research.

Some might declare it "a job well done," take a bow and stand down. But that would be a mistake! Too many pressing issues still challenge actors engaged in health promotion. Let's outline some of these issues and challenges:

- **Hospital-centric health care vs health promotion**. The statistics are brutal – in too many countries, most resources are allocated to curative functions and too little regard is given to health promotion, which falls under the umbrella of public action. Civil society organizations are expected to make their contributions with little means, or on an entirely voluntary basis.

  We therefore are challenged to allocate adequate resources to health promotion and not rely completely on volunteer labour.

- **Low-income countries vis-à-vis rich countries**. The gaps in health insurance coverage between poor countries and rich countries is truly enormous. If 100% of the population of Canada and many other western countries has full coverage, in too many African countries coverage extends to only 10% of the population. It is no easy matter to undertake structural initiatives in health promotion while access to basic health care services is not covered by insurance

  Health promotion actors therefore are challenged to support universal health coverage, a goal upheld by the WHO.

- **Inequality**. In addition to climate change, fighting inequality may be one of the principal challenges of the 21st Century. Health promotion actors can spare no effort to make the world more just and more equitable in terms of access to education, healthy environments, decent work, etc. The evidence-based work of Wilkinson and Pickett (2009) draws an undeniable link between inequality and life expectancy, mental illness and violence. Let's remember, these inequalities challenge low-income countries and rich countries alike. This is patently illustrated in the United States by the erosion of the middle class and the ever-widening gap between rich and poor.

  Health promotion actors are therefore challenged to proclaim loudly and clearly the issues, concerns and aspirations of a more just world!

As great as these challenges are, there is nothing to prevent us from exploring new

paths advantageous to the promotion of health and civil society. As Matthieu Ricard observes in his remarkable work, *Plaidoyer pour l'altruisme,* citing Professor Henry Mintzberg, civil society organizations are "[...] better able to create a collective dynamic of value creation, and to adopt responsible behaviours vis-à-vis common property: natural resources and human communities."[1]

Furthermore, the development of information technology and social media open up new opportunities for knowledge sharing and the dissemination of innovation, despite the challenges of distance. Thus, virtual communities of practice can be readily put in place. Such resources as YouTube or TED put videos and conferences no more than a click away. These capabilities, so conducive to synergies and to the structuring of an ecosystem of sharing, are converging as never before to enhance the strategies of the Ottawa Charter. It is for us to seize these opportunities!

[1] Ricard, Matthieu. 2013. *Plaidoyer pour l'altruisme La force de la bienveillance*. Paris Nil, p.764. For the reference to Mintzberg, see Mintzberg, H. 2014. "Rebalancing Society: radical renewal beyond left, right, and center." Retrieved October 3, 2016 (http://www.mintzberg.org/sites/default/files/rebalancing_society_pamphlet.pdf).

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6th Global Forum on HEALTH PROMOTION

6e Forum mondial sur la PROMOTION DE LA SANTÉ

Confederation Bridge