Health promotion, the Ottawa Charter and ‘developing personal skills’: a compact history of 25 years

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SUMMARY
The challenge of understanding what has happened in the 25 years since the Ottawa Charter would be difficult enough if there had been no Charter. However, our task is to interpret to what extent the Charter has influenced the world of health promotion as it is today. The task here is to consider what has happened regarding one action component of the Charter, notably developing personal skills. In taking only one of the five components, we are deconstructing the holistic approach that was implied in the Ottawa Charter and it is somewhat strange to isolate this action area from the others, and perhaps outside the ‘spirit’ of the Charter. Nonetheless, the approach will be to interpret this area broadly while still being restrictive and not venturing into discussions of the other action areas except where the connection is so strong that to isolate personal skills from the other area would be unproductive. The Ottawa Charter brought to the table, for health promotion and education, a growing recognition that health was a broad concept in its own right. It made explicit that ties to disease approaches were highly related to health education and promotion, but that health promotion had to go well beyond a narrow interpretation of the field. It recognized that active participation by people, to directly affect their health and the broader determinants of it, was paramount.

Key words: evidence-based health promotion; empowerment; global health promotion; values

INTRODUCTION
The challenge of understanding what has happened in the 25 years since the Ottawa Charter would be difficult enough if there had been no Charter. However, our task is to interpret to what extent the Charter has influenced today’s world of health promotion. This is a wicked causal problem and we need to say at the outset that we cannot possibly be certain of the causal connections that we imply in this paper. At best, ours is an interpretation, based on our knowledge and experience, of the character of the past 25 years given the existence of such a seminal document as the Ottawa Charter.

The task assigned is to consider what has happened regarding one specific action component of the Charter, notably developing personal skills. This was just one component among five. In taking only one of the five components, we are deconstructing the holistic approach that was implied in the Ottawa Charter and it is somewhat strange to isolate this action area from the others and perhaps outside the ‘spirit’ of the Charter. Nonetheless, the approach will be to interpret this area broadly while still being restrictive and not
venturing into discussions of the other action areas except where the connection is so strong that to isolate personal skills from the other area would be unproductive.

Before going further, we feel it necessary to consider some caveats with regard to solely addressing the concept of personal skills. First, we believe that it is artificial to fragment the components of the Ottawa Charter in order to analyze the effect of any one component, primarily because it undermines the essential spirit of the Charter, that emphasizes integration, and the relationship between all components. Second, it is difficult to consider the nature and impact of the charter itself, including the process to implement and sustain it, without considerable exploration of the context surrounding its development in the past 25 years. While the Charter itself was a catalyst for subsequent events, so was the surrounding context a catalyst for the Charter. For example, one could easily make a case for how the enormous changes in the media landscape that occurred during the last 25 years contributed to the dissemination of the Charter’s ideas. Indeed, one could argue that the rise of the personal computer and networking possibilities greatly enhanced the individual’s ability to explore all the dimensions of health, both social and personal. Third, there is the problem of how the separation of the Charter from the movement that immortalized it affects analysis of two critical areas. The first is the content of the Ottawa Charter which was able to capture the interest and willingness of diverse groups such as the international scientific community and agencies of international cooperation. These groups saw reflected in the Charter principles and values that had been part of the last decades’ social and political agendas in theory, but had not necessarily been incorporated in to health reforms, plans of action and investment. Likewise, the Charter was able to capture and interpret the historical process in health, evidencing ways of conceiving it, producing it and valuing it, in the light of new challenges, failures of old models and the rising of new phenomena related to the modernization, globalization, societal consciousness and, as a result, rising new paradigms of health. The second area which this separation affects is the nature of the movement, which was current, that strengthened the emerging new health promotion. There are characteristics of this movement that achieved what other movements were not able to. In the case of Latin America, the social movements of the 1960s and 1970s in favor of health and well-being of the people, that were diminished and often reduced to problems of healthcare systems, were far away from the conception of health promoting public systems. Finally, we would assert that one could also approach the given question of empowering individuals in terms of hypothesis testing. For example, regarding hypothesis testing for the case of personal skills, we would hypothesize that the environment plays and has played an important and dynamic role in both the formulation of the Charter statement and the ways it could be answered.

The Charter is witness to the fact that words are important, so there is a need for an exegesis of the statement on personal skills as it is specified in the Charter. The component states:

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

There are many critical concepts and principles imbedded in the statement. Notable are the words ‘information, education and enhancing’. These are three distinct ideas: information is a rather passive concept, education is about learning and skills are tools that an individual takes on. The next sentence is an ‘evidence statement’ that can be evaluated as in ‘it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health’. Such statements are often made as if they are truisms, however in reality they set up the possibility for falsification. Although it is rather safe to say that ‘evidence’ was not on the minds of the framers of the Ottawa Charter in 1986 (Evans et al., 2007), the statement here is one that could be tested. Furthermore, in the
ensuing 25 years, many of the expectations of such statements have indeed been tested and that testing is part of what has happened since Ottawa.

The second paragraph of the ‘develop personal skills’ component is a value judgment. This is apparent because of the use of the word ‘essential’. Furthermore, the whole statement implies that this value can be carried out through action in particular settings. There are, of course, many settings, but the Charter specifies school, home, work and community. Three are physical places, and community, of course, may be understood as both a physical and/or a conceptual idea. Given the placement in the text, it would imply a physical setting; however, as health promotion developed in the next 25 years, the concept of community became far more variant and complex.

Why is it important to note that part of the statement is ‘evidential’ and another part is a ‘value’ statement? In part because the 25 years of health promotion since the Charter have been very much occupied with providing evidence for health promotion and arguing that health promotion is essentially driven by some fundamental values that are shared by those working in the field (McQueen, 2007).

THE PROBLEM OF HISTORY

The question, ‘What has happened in the 25 years since Ottawa?’ is essentially a historical question, and in asking it is worthwhile to outline our historiographic approach. There are expectations of what would constitute an adequate answer or answers. The answer is, it depends. Are we interested in everything that happened or in just those events that can be linked to the Ottawa Charter? Obviously, ‘everything’ is well beyond the scope of a short article. However, just looking at linkage immediately introduces the implicit–explicit problem (more on this below). In taking such a historical approach we acknowledge our obvious biases: one author was a contributor to the Ottawa Charter; both authors are limited by language to English, Spanish and German; more importantly there are no traditional ‘histories’ of the Ottawa Charter and/or health promotion to consult. Others need to add to the history.

In trying to answer the question, we are challenged by what methodology to employ. Much of history is approached through narrative. Indeed, the broad notion of ‘narrative’ has recently been taken up and championed by many in the field of health promotion (Riley and Hawe, 2005; Larkey and Hecht, 2010). Basically, in history, the narrative approach is quite simply a chronological descriptive story of what has happened and in general is concerned with people rather than ideas. It tends to lay out the particular rather than the general and relies on anecdotal rather than so-called ‘scientific’ information. Social historians tended to discount narrative approaches and sought a more empirical approach; however, historiographic approaches wax and wane in favor in the academy. For our purposes, we would tend to take a more social history approach rather than a narrative of who did what and when.

In any case, the narrative approach tends to lead to a discussion of the ‘champions’ of health promotion and what they did in the ensuing 25 years, whereas the social history approach tends to lead to a history-of-ideas point of view. Interestingly, the section of the Ottawa Charter on developing personal skills does not provide an easy answer as to which methodology might best serve our general question. The evidential part of the section would suggest an analytic, social history that follows how the ideas were either taken up or rejected, whereas the value-laden component might be more applicable studied through a narrative approach. As the first author of this paper was trained in a history-of-ideas approach, the comfort level with the conceptual ideas is to be noted.

The essential historical question concerning the Ottawa Charter is: ‘If health promotion was “in the air” in 1986, how come the Ottawa Charter caught it?’ This is a history-of-ideas question. For those of us who have studied, administered, taught and practiced health promotion over the past 30 years, there is little doubt that the Ottawa Charter was a prime catalyst in what followed. Whether that influence was as great in the area of developing skills remains more conjectural. Health education, which had a primary role in the area of information and health, as well as considerable involvement with the school setting in particular, was already quite well established in many countries before the Ottawa Charter (Weare, 1992). Indeed, in the US, health education had departments in academia and
practitioners in state and local health departments, with funding of projects from leading US health agencies such as NIH and CDC. From an American perspective, the area of developing personal skills could be viewed as well funded and developed with sound theoretical and practical approaches. Thus, this component of the Ottawa Charter may have had a head start in application in many quarters. However, for many, the relevance and importance of the Charter as a whole for many health education practitioners may have been perceived as outside their realm of activity. For others, it might tie their work to the broader concept of health promotion.

THE CHALLENGE OF EVIDENCE

During the 25 years since the Ottawa Charter, the problem of evidence in health promotion has risen in salience. This particularly became the case in the early 1990s with the rise of, and connection to, the notion of evidence-based medicine. In general, this notion was championed by many in the public health community and health promotion was not immune to the pressure to provide ‘evidence’ of its actions. Many public institutions as well as NGOs took up the challenge of evidence through publications, official committees and multiple structural responses. While there is clearly no room in a brief article to review the largesse of efforts that have been undertaken, there are good summary monographs and documents that deal with this ‘evidence’ question.

The point is clear, that the Ottawa Charter as a total document did not deal with the unanticipated evidence challenge. However, as noted above, there were evidentiary statements made in the Charter and it was only a matter of time before many of the Charter sections would be challenged by the evidence debate. This challenge holds particularly true for the section on developing personal skills. This may be inferred by the fact that many of the classical methodological and research designs implied in this area have been and still are established on a grounding of psychosocial and epidemiological research. The point is that many of the most readily measurable constructs in health education and promotion are found in the personal skills section and social and biomedical researchers have for many years been creating measures and methods that lend to an empirical evidentiary approach. The success and limitations of such approaches have been well documented through the years as evidenced in the work of the US task force on community preventive services (cf. Zaza et al., 2005).

The Ottawa Charter section on developing personal skills was evident in the elaborate project and subsequent report for the European Commission on the evidence of health promotion effectiveness (EC/IUHPE, 1999). This project carried out by the IUHPE by an international advisory group with participants from Europe, North America and Australia clearly had a strong theoretical orientation in the Ottawa Charter. Two documents were produced, a comprehensive ‘Evidence Book’ with a specific chapter (Chapter 12) dedicated to the direct Canadian and Ottawa Charter influence and a ‘Core Document’ that laid out the bare bones arguments for evidence that health promotion works. Much of the documentation and argument for evidence deals directly with developing personal skills as asserted in the Charter. Thus, particular attention was paid to the school and workplace as settings for health promotion action. Of course, there were the usual discussions of health promotion programs to address tobacco, physical activity, nutrition and alcohol, but they were almost all advocating approaches that go beyond personal skills and leaning toward broader action approaches dealing with policy. Nonetheless, the advocacy was generally in the direction of developing skills for community approaches that would not be inconsistent with the implications of the Ottawa Charter. The report did have a history of influence, guided many of the activities of the IUHPE in the following years and was published by health agencies throughout the world into multiple languages.

In June 1995, the WHO Regional Office for Europe established a working group on health promotion evaluation in cooperation with three government agencies, the CDC in the USA, Health Canada and the Health Education Authority of the UK (the latter two agencies no longer exist, however, their functions are in a new organizational format). This working group met multiple times, over many years, commissioning some 30 papers, producing resource documents and conducting multiple workshops, culminating in the publication of the oft-called ‘yellow book on evaluation’ in 2001 (Rootman et al., 2001). Among the guiding principles that the working group chose was one that stated
‘empowering (enabling individuals and communities to assume more power over the personal, socioeconomic and environmental factors that affect their health; . . . ’ (p. 4). In the subsequent sections that dealt with perspectives, settings, policies and systems and a synthesis, the Ottawa Charter was often either cited directly or implicit. Many of the authors had worked on the background concepts and principles document that preceded the Ottawa Charter (No Author, 1986), and many were attendees in Ottawa. In addition, the volume was certainly witness to the rise and importance of participatory approaches in health promotion and the recognition that such approaches were directly tied to the development of personal skills.

Following the interest created by the EC report mentioned above, the IUHPE undertook a longer-term project to look at the global perspectives related to the challenge of evidence. One of the driving questions of the global program on health promotion effectiveness (GPHPE) was the extent to which the actions in the Ottawa Charter would be reflected in evidence efforts around the globe. It is telling that in the introductory chapter of a book published on the GPHPE in 2007, the editors state: ‘In the reading, editing and reviewing of the chapters in this monograph many additional and critical topics have arisen. We propose here three topics that need to be highlighted because they occur in one form or another in practically every chapter, namely: methodology, measurement, and the Ottawa Charter’ (McQueen and Jones, 2007; p. 6). While the Charter is often referenced in the discussions of evidence and effectiveness, it is usually in terms of what is implied by the Charter. Again this is partly because of the lack of evidence seeking specificity in the Charter itself and brings up the issue, discussed briefly below, of implied versus explicit attribution of the Charter’s influence in the past 25 years.

THE VALUE CONNECTION

We asserted in the introduction above that another avenue of assessing the impact of the Ottawa Charter over the past 25 years was in the dimension of ‘values’. Throughout the Ottawa Charter are many statements that assume underlying agreement on values. Health is a value; equity is a value; social justice is a value. One could cite many such value-laden notions that underlay health promotion and specifically the health promotion that is expressed in the Charter. It is not the place to engage in the complicated dynamics of the ‘values’ discussion, but one should be cognizant of the current debates in health and health promotion that have value-laden implications and their possible connections to the Charter.

The questions of values are not totally separated from the evidence challenge discussed above. This is because many have come to believe that the evidence of what improves health, whether from personal enabling skills or socioenvironmental changes, is highly related to socio-cultural determinants of health that are in the value region of thought. Hence, the present-day models of health promotion have pooled much of the holistic approach of the Ottawa Charter into models that identify variables such as poverty, equity, social justice, empowerment, etc. The resulting upstream causality thinking implied heavily in the Ottawa Charter has yielded a complex contemporary discussion of attribution of effect. It is remarkable that at present a heavily epidemiologically-based report such as that of the SDOH commission now incorporates much of the implied values found in the Ottawa Charter, but without any specific recognition of this origin (CSDH, 2008). Nonetheless, values have entered deeply into health promotion theory, practice and research and many of these values stem from the Charter. This was made more clear in a recent publication on values and research in health promotion evaluation practices in the Americas (Potvin and McQueen, 2008). One purpose of this publication was to follow up on the lack of more discussion of evidence from all the Americas and notably the south that was observed in the work on the IUHPE GPHPE cited above. In a background chapter on the divergent and common grounds for health promotion in the Americas, de Salazar and Anderson point out: ‘While the principles of health promotion set forth in the Ottawa Charter resonate in Latin America, the historical foundations of health promotion differ. A long tradition of social medicine provides philosophical and theoretical underpinning to Latin American health promotion practice, which is absent, to a large degree, in the North.’ (de Salazar and Anderson, 2008; p. 16). Many of the efforts in Latin America concentrated on the values of equity and resulted in efforts to redistribute income. In addition, the powerful empowerment
strategies in Paulo Freire’s writings worked to create a concentration on ideas of social justice and equity (Waitzkin, et al., 2001). Thus, when we consider the empowerment issue as outlined in the Ottawa Charter, we should be cognizant that empowerment as a concept is essentially an interpretive concept that has been embraced differently in different contexts. The history of ideas challenge is to consider the commonalities and differences in the concept in their context.

In essence, the empowerment concept is taken in a seemingly different direction in the south. It combines several notions that arise from the Charter including individual and collective capacity and participation, a view well developed by Wallerstein (1992, 2006). In a Chapter on dilemmas in health promotion empowerment in Potvin and McQueen (2008), MacDonald and Mullett challenged the concept as it developed from the Ottawa Charter:

The editors initially defined empowerment as enabling individuals and communities to assume more power and control over the personal, socioeconomic and environmental factors that affect their health. This aligns closely with the definition of health promotion in the Ottawa Charter and so, to distinguish empowerment from health promotion, we prefer a blend of the definitions identified by Butterfoss and Wallerstein. Empowerment is a multilevel construct that describes a social action process by which individuals gain mastery over their lives, their organizations, and their communities, in the context of changing their social and political environment, to improve equity and quality of life (MacDonald and Mullett, 2008, p. 150).

There is a broad literature that could be introduced on values here. We have chosen the examples above because they relate to that piece of the Charter under examination. Suffice it to say that the discussion on values has blossomed profoundly in the 25 years since the Ottawa Charter, and these discussions have been relevant for all parts of the Charter. However, the Charter’s specific influence on values with regard to enablement has been enhanced and elaborated globally.

**GENERAL COMMENTS AND SUMMARY**

In a critical review paper such as this, assessing one action component of the Ottawa Charter and what happened in the ensuing 25 years, there are many approaches that could have been taken. We have concentrated on an approach that emphasized the history of ideas and in particular how the Charter has influenced the evaluation in the area of developing personal skills. In this section, we will briefly review some alternative possibilities for consideration in future writings, keeping in mind the enormous relevant literature that could be taken into account.

One approach of interest would be to follow the development of models for health promotion that have emerged in the past 25 years and explore their content and rationales for links of influence. There are many relevant models, including RM Andersen’s model of Health Care Utilization (Andersen, 1995); Lisa Berkman’s model of Upstream/Downstream determinants (Berkman et al., 2000); Hamilton and Bhatti’s Integrated Framework for Population Health Promotion (Hamilton and Bhatti, 1995); Dahlgren and Whitehead’s model of layered influences on health (Dahlgren and Whitehead, 1992); Etches’ model (Etches et al., 2006); Evans and Stoddart: The CIAR Model (Evans and Stoddart, 1990); Green’s Precede-Proceed framework and associated models (Green and Kreuter, 1991) the Obesity Model from the International Obesity Task Force (Kumanyika et al., 2006); Brunner and Marmot’s models (2006); Starfield’s model of determinants (Starfield, 2001); and one should include all the versions of the SDOH models leading to the final conceptualization in the SDOH Commission report (CSDH, 2008). This is hardly an exhaustive list, there are many other models related to stress, work, biomedical functioning and general social models that are pertinent (cf. Krieger, 2011). Of course, the Ottawa Charter logo is itself a model that has been featured quite often. The main point is that many of these models have probably been influenced by the Ottawa Charter. Deciding on the level of attribution to give to the Ottawa Charter, and particularly the action point on developing personal skills, would require a very comprehensive review of this activity. Models remain a favorite ploy of many who work in health promotion and will undoubtedly continue to be so. No doubt the power of visual images that can be created by modern personal computers has contributed to the proliferation of image over text.

The model connection again raises the point that is relevant throughout this paper: the
problem of distinguishing what is explicit versus implicit regarding the impact of the Charter in the past 25 years. In this age of high-powered computer search engines, it is relatively easy to find explicit references to the Charter in the vast health promotion literature. However, even in this case, if one specifies developing personal skills and links to the Charter, the search results are very thin. This is a common historiographic problem for the modern researcher and is a compelling reason why most inquiry has to then move to the realm of implied connections. Thus, much of what we can state remains interpretive. This is not a problem, rather it is the challenge of attribution. Those of us who have worked with the Ottawa Charter and indeed those of us who were present at the Charter-related events are more likely to fall prey to positive attribution of writings on the effect of the Charter. In doing so, we are challenged to be as reflexive as possible to separate out our notion of reality from the purported evidence of attribution (McQueen et al., 2007).

It would be amiss in this paper not to consider the changing nature of health education in the past 25 years. As has been noted above, at the time of the Ottawa Charter health education as a field of work in public health was quite advanced in many countries, notably in the USA. In addition, the present day IUHPE had been established as the International Union of Health Education some 35 years earlier in 1961 and had a strong international focus by the time of the Charter. Relatively little has been written about the focus in the Charter away from what was seen as individual-based traditional health education, but those not familiar with this notion would find some interesting exchanges (cf. Raeburn and Peters, 1987), including those in the online discussion forum of the IUHPE (cf. Green, 2005). Writing in the same forum, Don Nutbeam (2005) wrote, regarding personal skills:

The development of the concept and principles of health promotion were, to some extent, responses to unduly simplistic, individual behavioural health interventions that had emerged in the 1970’s and early 80’s. The Ottawa Charter makes clear that efforts to develop personal skills through traditional health education methods are only a part of a more complex and sophisticated set of tools to promote good health. Despite this discussion and the myriad of behind-the-scenes debate on this, health education was already playing a strong role in many countries in the area of developing personal skills and many in health education believed that health education was the ideal base for health promotion. The Ottawa Charter seemingly offered a broader vision for health promotion, but in doing so seemed to imply that health education was a limited approach. It is difficult to quantify, but if one seeks to understand why the Ottawa Charter is not cited so explicitly, particularly in American literature on health education and promotion, it may well be because of heavy influence of so-perceived upstream thinking implied in the Charter. Nonetheless, health promotion did take on the mantle of education as a key tool for health promotion in many guises, perhaps most decidedly in embracing the concept of health literacy. This duality in the development of health promotion after the charter is nicely discussed and put in context by Milton Terris (1992).

What the Ottawa Charter brought to the table, both for health promotion and education, was a growing recognition that health was a broad concept in its own right. Furthermore, it made explicit that ties to disease approaches were highly related to health education and promotion, but that health promotion had to go well beyond a narrow interpretation of the field. Third, it recognized that active participation by people to directly affect their health and the broader determinants of it was paramount. However, one cannot close a paper like this without noting that the Ottawa Charter was also reacting to many of the emerging ideas of the time that were outside the biomedical and public health sectors. A number of key notions were arriving on the table; equity, salutogenesis (Antonovsky, 1979), healthy cities (Ashton 1989), complexity, participation, context and others. These were followed by ideas that came into full-blown emergence such as salutogenesis (Eriksson and Lindström, 2008), urbanization, settings (Poland et al., 2000), civil society, social capital, climate change, social justice and others (cf. McQueen et al., 2007).

Finally, the big question to contemplate concerning the Ottawa Charter and developing personal skills is: What would have happened if there had been no Charter? How different would the contemporary world of health promotion look?

REFERENCES


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