Ottawa 1986: back to the future

Roads? Where we’re going, we don’t need roads

Doc Brown in a cinema near you, 1986

When Ottawa’s starting pistol was fired in the snow blizzards of November 1986, who would have thought that the health promotion race would have sped so long and so hard without roads? Across the world, there are government health promotion strategies and reviews, statutory authorities and foundations, consumer interest groups, professional associations and journals. University departments and professors proudly bear the name, Masters and Bachelor degrees are in abundance and a new book seems to appear every few months.

Millions of dollars are increasingly being invested in health promotion programmes by governments and international organizations, like the World Bank, as well as through voluntary contributions from people themselves. Outcomes are now obvious globally from a health-promoting school in Africa to a health-promoting market in Asia, to a health-promoting hospital in Europe and to a health-promoting city in South America. Smoking has fallen in many countries, HIV has been curbed, road injuries prevented and mental health promotion centre-staged. It is quite remarkable that this has all happened in just a quarter of a century.

Perhaps there are times when stars align, forces unite, nature speaks and people have their day. This was true for the year 1986 when the Internet Mail Access Protocol was defined—opening the way for e-mail—and IBM unveiled the PC Convertible, the first laptop computer. That same year the Human Genome Project was launched laying down the foundations for a new era in health and medical research. In the USA, smoking was banned on all public transport and the nicotine patch was invented. In the UK, bovine spongiform encephalopathy, commonly known as mad cow disease, was first identified and caused many deaths over the next few years and a major reform in farming practices. Sadly, the worst ever nuclear disaster occurred as the Chernobyl Nuclear Power Station causing the release of radioactive material across much of Europe.

Following a number of trouble-free years in space exploration, the Space Shuttle Challenger exploded shortly after takeoff watched by people live on TV around the world. The Soviet Union launched the Mir space station and President Gorbachev introduced Perestroika (restructuring) and Glasnost (openness). There was also an important ‘breakthrough’ in US–USSR Arms Talks leading to a commitment to disarm which ended the long period of instability of the Cold War. And to cap the year off, there was the Ottawa Charter.

Looking back, the origins of health promotion are complex and no single driver is responsible. However, most commentators would agree that the shift in thinking began to occur around an important global meeting of WHO at Alma Ata, Kazak, in the former Soviet Union in 1978 (WHO, 1978). The Declaration of Alma Ata formally adopted Primary Health Care as the principle mechanism for health-care delivery. It crucially recognized that health improvements would not occur just by developing more health services or by imposing public health solutions from the centre. Alma Ata heralded a shift in power from the providers of health services to the consumers of those health services and the wider community. This led WHO, in 1981, to prepare a global strategy Health for All by the Year 2000 with a series of measurable targets and goals (WHO, 1981). This initiative became the driving force for comprehensive health development over the following two decades and
provided the right environment for the concept of health promotion to foster and grow.

In 1981, the WHO Regional Committee for Europe adopted a resolution on health education and lifestyles that established a new approach to health education based on a social concept of health (EUR/RC 31/10). In the same year, the European Office of the International Union for Health Education published and disseminated a paper on a social concept of health education (Kickbusch, 1981). These and other discussions (e.g. WHO, 1983) were critical in establishing a lifestyles approach to health education and health promotion which prompted the Regional Committee to establish a new programme area at the WHO Regional Office for Europe in Copenhagen. Work commenced in 1984, the year that the Regional Committee adopted 38 regional targets for Health for All including a set focusing on lifestyles conducive to health (WHO, 1985).

During the early 1980s, the term ‘health promotion’ was becoming increasingly used by a new wave of public health activists who were dissatisfied with the rather traditional and top-down approaches of ‘health education’ and ‘disease prevention’. It signalled a positive, creative and outcome-oriented approach. However, in some contexts and languages, the term ‘promotion’ was considered synonymous with ‘marketing’ and ‘selling’ rather than ‘enhancement’ and ‘empowerment’. This prompted the WHO to call a special meeting in late 1984 in Copenhagen Denmark to provide some clarity and direction which led to the first substantive document on health promotion. The Concepts and Principles of Health Promotion later published in the first edition of Health Promotion International became the springboard for the Ottawa Conference and Charter (WHO, 1984).

As part of the continuing process of discussion on health promotion, the WHO Regional Office for Europe jointly organized a workshop in July 1985 with the Welsh Heart Programme organization in Cardiff, UK. A discussion document was developed on the practical aspects of implementing health promotion programmes, which became a key resource for the emerging Heartbeat Wales programme and other major community-based interventions (Catford et al., 1987). Later in December that year, a framework for health promotion policy was developed at Noordwijk, Netherlands (WHO, 1986a,b,c), and subsequently published through WHO EURO. A glossary of health promotion terms was also produced (Nutbeam, 1986) which was then made available in five languages.

These initiatives and many others created the platform for the Ottawa Conference in November 1986 (WHO, 1986a). It was organized by WHO in partnership with the Canadian Government and the Public Health Association of Canada and bought together 212 representatives from 38 countries. Ottawa is seen as the formal birthplace of health promotion; not only did it endorse and legitimize some of the work that had been going on behind the scenes through WHO, but it cascaded action into a number of countries. The Charter that emerged is now considered the bedrock of the health promotion movement (WHO, 1986b) and the logo has been used and adapted over the years to signal the overarching themes and approaches of health promotion (WHO, 1986c).

Looking back 25 years later, the key achievement of Ottawa 1986 was to legitimate the vision of health promotion by clarifying the key concepts, highlighting the conditions and resources required for health and identifying key actions and basic strategies to pursue the WHO policy of Health for All (WHO, 1986a). Importantly the Ottawa Charter that emerged also identified the prerequisites for health, including peace, a stable ecosystem, social justice and equity, and resources such as education, food and income (WHO, 1986b). It highlighted the role of organizations, systems and communities, as well as individual behaviours and capacities, in creating choices and opportunities for better health. Since then the WHO has organized, in partnership with national governments and associations, a series of follow-up conferences, which have focused on each of the Ottawa Charter’s five health promotion strategies.

Building healthy public policy was explored in greater depth at the Second International Conference on Health Promotion in Adelaide, Australia, in 1988. Organized to coincide with Australia’s bicentenary, an invited audience from mainly developed countries created the Adelaide Recommendations on Healthy Public Policy (WHO, 1988). It called for a political commitment to health by all sectors. Policy-makers in diverse agencies working at various levels (international, national, regional
and local) were urged to increase investments in health and to consider the impact of their decisions on health.

The focus of the Third International Conference on Health Promotion in Sundsvall, Sweden, in 1991 was on creating supportive environments (WHO, 1991). Coming at a critically important time, it provided the first opportunity for health professionals from all over the world to consider how environments—whether physical, social, economic or political—can be made more supportive for health. Armed conflict, rapid population growth, inadequate food, lack of means of self-determination and degradation of natural resources were among the environmental influences identified at the conference as being damaging to health. The Sundsvall Statement on Supportive Environments for Health stressed the importance of sustainable development and urged social action at the community level, with people as the driving force of development (WHO, 1988). This statement and the report from the meeting were presented at the Rio Earth Summit in 1992 and contributed to the development of Agenda 21.

The Fourth International Conference on Health Promotion held in Jakarta, Indonesia, in 1997 reviewed the impact of the Ottawa Charter and engaged new players to meet global challenges. The practice of health promotion was now becoming mainstream and required greater rigour in its application (Catford, 1993). It was the first of the four International Conferences on Health Promotion to be held in a developing country and the first to involve the private sector in an active way. The evidence presented showed that health promotion strategies can contribute to the improvement of health and the prevention of diseases in developing and developed countries alike (Kickbusch, 1997). Five priorities were identified in the Jakarta Declaration on Health Promotion into the 21st Century (WHO, 1997). These were confirmed in May 1998 through the World Health Assembly Resolution on Health Promotion WHA 51.12 (WHO, 1998).

Despite all the progress and developments in health promotion over the previous decade, two important challenges still remained (Catford, 1997). The first was to demonstrate and communicate more widely to developing countries that health promotion policies and practices can make a difference to health and quality of life (Nutbeam, 1998). The second was even more important; that health promotion action can achieve greater equity in health and can close the health gap between population groups. In response, the Fifth Global Conference on Health Promotion in Mexico in 2000 focused on health inequalities both within and between countries. The Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action affirmed the contribution of health promotion strategies in sustaining local, national and international actions in health (WHO, 2000). It also pledged to draw up country-wide plans of action to monitor progress made in incorporating strategies that promote health into national and local policy and planning.

With the birth of a new millennium, it became increasingly apparent, however, that the world was changing fundamentally and this included our understanding of the determinants of health. Opportunities and challenges had emerged which were unthought of in 1986 such as the internet, the human genome project, climate change, terrorism, geopolitical change, third world debt and globalization of people, money, products and services. The struggle was now about connecting global influences with everyday life and managing them to our best ability.

Against this context, the Sixth Global Conference on Health Promotion in Bangkok was organized in 2005, which was structured around four thematic tracks: the new context, health-friendly globalization, partners and sustainability. Participants reviewed and soundly endorsed the original five Ottawa action areas, but they also found that building capacity to promote health goes beyond community and skills development; it includes global and local policy, partnerships and alliances, finance and information systems, and trade considerations (WHO, 2005). Through the Bangkok Charter for Health Promotion in a Globalized World four new commitments were identified: make the promotion of health (i) central to the global development agenda, (ii) a core responsibility for all of government, (iii) a key focus of communities and civil society, and (iv) a requirement for good corporate practices.

The lack of sufficient progress in implementation led the Kenyan Government and WHO to host the Seventh Global Conference on Health Promotion in 2009. Implementation gaps existed in evidence, policy, practice,
governance and political will, resulting in a failure to realize the full potential of health promotion (Catford, 2006). This represented a lost opportunity, measured in avoidable illness and suffering as well as the broader social and economic impacts.

While the Conference brought together over 600 experts from more than 100 countries, there was very strong representation from African countries which provided a unique dimension to the discussions, debates and presentations. They were complemented by an equal number of virtual participants who registered on a new social networking site (www.connect2change.org)—another first for the health promotion community. Inevitably, the Conference statement, the Nairobi Call to Action, which emerged 5 days later has strong African perspectives (WHO, 2009). The Nairobi Call to Action highlighted the following urgent responsibilities to (i) strengthen leadership and workforces, (ii) mainstream health promotion, (iii) empower communities and individuals, (iv) enhance participatory processes, and (v) build and apply knowledge.

Much credit for this truly pioneering work goes to Dr Ilona Kickbusch. She was the key instigator of WHO’s approach to health promotion and was extremely successful in placing it high on international, national and local health agendas. For example, her leadership enabled the 51st World Health Assembly to adopt the first global health promotion resolution and urge all member states to implement the five priorities set out in the Jakarta Declaration (WHO, 1998). Ilona Kickbusch was the Director of WHO’s Division of Health Promotion, Education and Communication in Geneva and was previously in a similar position at WHO’s Regional Office for Europe in Copenhagen. She was one of the founders of the journal Health Promotion International in 1986 and currently stills chairs the Editorial Board.

Over the 25 years since the Ottawa Conference and Charter, there have been major and diverse shifts in thinking, policy and action for better health at local, national and international levels. But a clear thread can be detected which leads back to this meeting of free thinkers from 50 countries which developed and affirmed a series of principles and actions framing the value systems and practice of health promotion. Much has been achieved and much still needs to be done, but whatever the blind spots and shortcomings, the Ottawa Conference and Charter has been the fulcrum or tipping point in global health development. Ottawa 1986 bridged the past successes of the public health reforms with the aspirations of the new health promotion movement. It has shaped and will continue to shape the world’s health destiny.

In his 1986 State of the Union Address, President Ronald Reagan quoted one of the most successful sci-fi films ever, Back to the Future. In response to the jibe ‘Why even bother, McFly? You don’t have a chance; you’re too much like your old man. No McFly ever amounted to anything in the history of Hill Valley’, Marty McFly responded, ‘Yeah, well, history is gonna change’. I remember people making similar pronouncements 25 years ago about the week-long work we had been doing together in a snowed in hotel in Canada. But unlike Back to the Future, Ottawa 1986 was a real phenomenon and it did change history.

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REFERENCES