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# Crafting Health Promotion: from Ottawa to beyond Shanghai

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## Impact and change

This year there are celebrations, around the world, of the 30<sup>th</sup> anniversary of the Ottawa Charter. We have seen similar celebrations five years (e.g., De Leeuw 2011, REFIPS 2012) and ten years ago (e.g., Baum 2007, Ridde, Guichard & Houeto 2007). The Charter remains visionary and inspirational, with a lasting legacy. But it has not delivered on its vision comprehensively. Two of its action areas stand out as having failed to show real evidence of

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<sup>1</sup> Evelyne de Leeuw attended the International conference on health promotion in Ottawa, November 1986, and all subsequent Global Conferences on Health Promotion. She may not be in Shanghai.

success: the call to build healthy public policy, and the need to reorient health services for health promotion.

'Healthy Public Policy' has now been replaced by 'Health in All Policies' (De Leeuw, Ståhl & Tang (2014). 'Reorientation of Health Services' still struggles. Both of these, in our assessment (de Leeuw 2017), suffer from the relative marginalisation of health promotion advocacy on the fringe of the mainstream medical-industrial complex. Clinical care and the pharma and biomedical technology sector continue to grow, while public health and health promotion remain on the resource and policy periphery. A partial solution to this challenge is for the global health promotion community to embrace a health political science (Bernier & Clavier 2011, Clavier & de Leeuw 2013). This would explain the political process for making choices in the public domain, and explicitly recognise issues of power, perception and trade-offs.

The world of 2016 is very different from the world of 1986. Socialist states and Marxism-Leninism have all but disappeared from the face of the earth. Globalisation and its neoliberal market dictatorship is now the dominant and virtually unchallenged ideology (Labonté 2016). Progress has been made but it has not been shared by all. Humanity as a whole is doing better, but differences between populations and groups persist and grow, in terms of health, well-being, wealth and life opportunities. Knowledge, information and entertainment are available everywhere and anytime, at mind-numbing speeds, qualities and quantities. The gap in the ozone layer may have closed, and acid rain disappeared, but they have been replaced by the seemingly unstoppable advent of the slow disaster of climate change. Rampant population growth and (often disaster-driven) mobility have led to an urban planet with hundreds of millions living in camps, slums and on the fringe. The ecosystem services that buffer hardships for these people – fresh air, clean water, food, fuel, building materials, and protection from flooding – are collapsing.

Against this backdrop, the government of the People's Republic of China with the World Health Organization is organising the Ninth Global Conference on Health Promotion in Shanghai in November 2016.

In this world - is the Ottawa Charter still relevant? Is the Shanghai Declaration on Health Promotion going to have the visionary and lasting impact the Charter had?

## Understanding the Charter

In answering these two questions it is important to recognise how the first health promotion conference – in Ottawa - came about. It was a carefully curated event that built on a series of earlier events and publications. These were themselves responsively crafted to integrate slow revolutions that had swept the world after the Second World War. This may sound abstract but it simply recognises that the Ottawa Charter was not only visionary in its wording, it was also serendipitous in its timing and focused on creating social synergies.

The appraisal of how unique and well-strategised the Charter is could start with an interpretation of its cover (figure 1). Unlike any of its 'children' of the next Global

Conferences on Health Promotion (Adelaide; Sundsvall; Jakarta; Mexico; Bangkok; Nairobi; and Helsinki) the paper is bilingual. It is also the briefest of all – just two pages. The logos of the three co-organisers include civil society in the form of the Canadian Public Health Association, and not just a nation-state WHO counterpart. But most importantly, the motto of the conference is what most health promotion historians seem to have forgotten: *the move towards a new public health*.

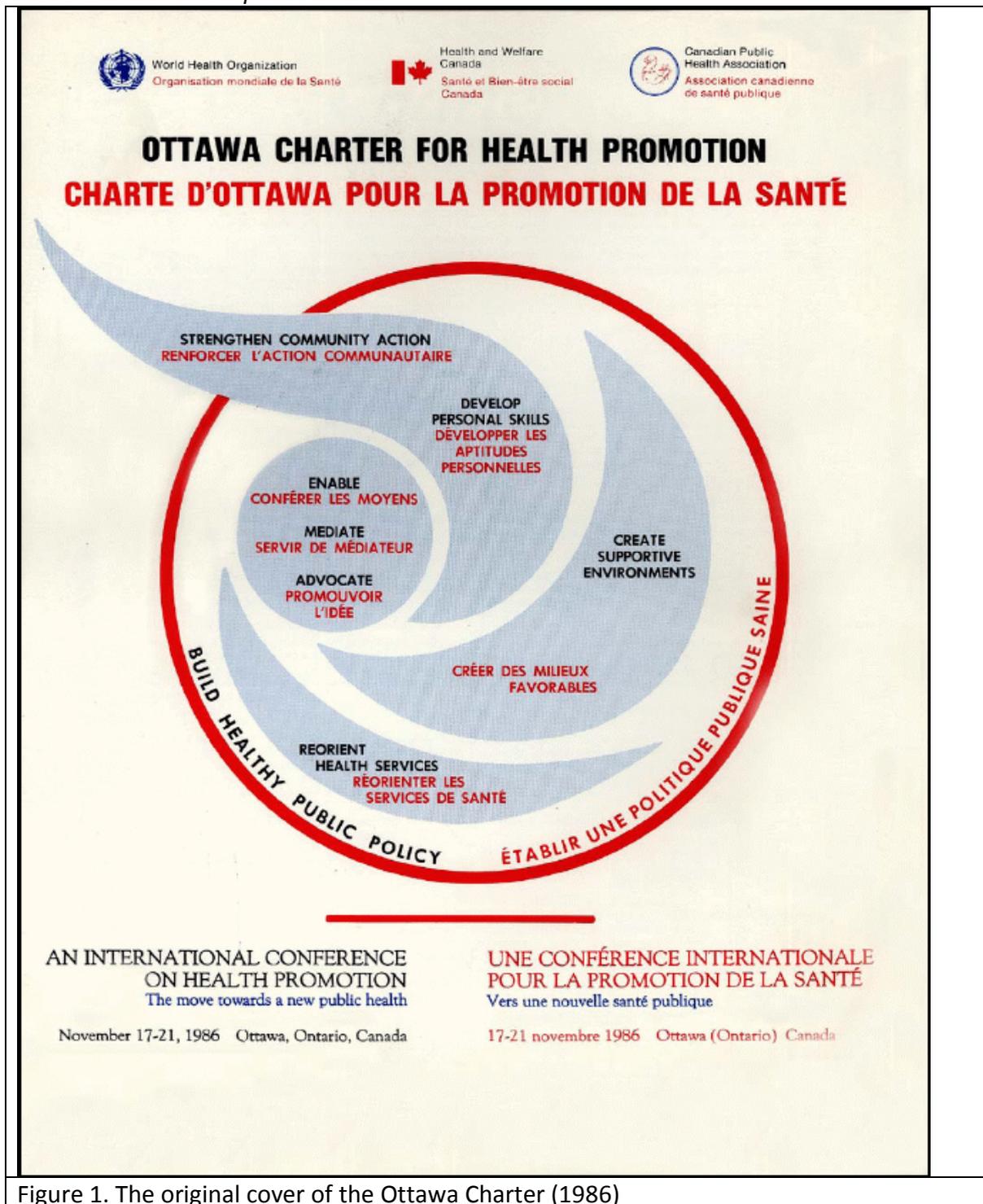


Figure 1. The original cover of the Ottawa Charter (1986)

There has been considerable debate what this 'new public health' could be. In a best-selling publication, now in its fourth edition, Fran Baum (2015) explains that a new public health is

inclusive of civil society and a range of models of health (including Indigenous, social, and biomedical). It embraces communities as holders of expertise and evidence. New public health seeks to understand and address the chain of causes, and the causes of the causes, of health. It endeavours to build upon the health assets of individuals, groups, communities and structures, rather than trying to fix deficits only. The new public health values diversity and complexity, and rather than trying to simplify things attempts to make sense of the fluid and multi-level dynamics that create, sustain and challenge health. Most of all perhaps, the new public health is about equity, justice and sustainability – and not individual health alone.

Our understanding of these things has grown since the publication of the Ottawa Charter. Although most of this is now mainstream rhetoric, it certainly is not mainstream practice. In particular the policy dimension of the necessary joined-up responses to the current complexities of both individual and population health is barely understood or implemented (De Leeuw 2017).

The Shanghai celebration has chosen four pivots for discussing the future of health promotion: Healthy Cities; action across sectors; social mobilization; and health literacy. In its current form it fails to embrace and tackle complexity, adopt a systems science approach to it, or to identify interests in a multi-level governance framework in those systems (e.g., Hill & Hupe 2006, in De Leeuw 2017) – and the essential role of health leadership (e.g., Greer & Lilvis 2014) in navigating this space.

### How was 'Ottawa' different?

Why has the Charter had such lasting stature? The casual observer may say that it was developed at a meeting that brought together the right people, in the right place, at the right time. Some of that is true – certain dynamics cannot be orchestrated. But a more profound analysis would show that the meeting in Ottawa was the culmination of a deliberate effort that had taken considerable time and strategy. In the years before 1986 a series of documents had been produced on matters such as social futures, lifestyles and health, strategic health policy development, and the determinants of health (de Leeuw 1989). The development of these papers had brought together groups of like-minded people with a clear sense of the evidence base for a new public health. One that moved from the technocratic to the engaged and empowered. The people behind the Ottawa Charter not only recognised the change in social currents that happened between the 1960s and 1980s, they actively shaped and funnelled these into a scholarly activist meeting and outcome document.

Of note, the voices of Indigenous peoples and developing countries were less central in the development of the Ottawa Charter than we would expect now (McPhail-Bell et al 2013), which itself should be regarded as a challenge for the for the crafting of the Shanghai Declaration. Will the Ninth Global Conference on Health Promotion embrace the need to be inclusive and carefully shaped? Some would say that the world has become so complex and interconnected that careful strategising for an impactful and visionary statement has become impossible. I do not agree.

The four themes chosen to drive the thirtieth anniversary re-engagement are appropriate, but they are not the most shrewd. They may not allow for the right people, at the right time, to discuss what really matters, based on a carefully shaped set of conditions.

What really matters? A few thoughts: the wealth and health equity gap, and the corporate power that drives its widening; xenophobia, religious and populist fanaticism and a regression from global integration to fortress nation states; the insidious and often unchecked meshed food and medical industrial complex that creates more dependency and less empowerment; giving a voice to the powerless and those left behind in social transformations; and as a result of our failure to deal with these: intergenerational environmental injustice.

Admittedly, tackling these sound very complex, and difficult. To advance action on such critical issues we need more than scholarship and activism. The world needs courage and leadership. We need a vision for a healthier future that speaks to the world we find ourselves in now.

The leader of the World Health Organisation, Dr. Margaret Chan, earlier this year audaciously identified these issues in her address to the World Health Assembly (Chan, 2016). But leadership implies followship: WHO member states need to accept the challenge and initiate action.

There will be a Tenth Global Conference on Health Promotion. Let's hope it will celebrate the achievements of the Ninth, and of the Ottawa Charter. And let's pray it can be shaped and strategised to deal with what matters.

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