Are we there yet? Use of the Ottawa Charter action areas in the perspective of European health promotion professionals

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Introduction

The Ottawa Charter for Health Promotion, sub-titled “The Move Towards a New Public Health,” has been identified as an influential and guiding document and tool (IUHPE and CCHPR 2008; Baum and Sanders 2011) responsible for laying a foundation for health promotion theory and practice (IUHPE and CCHPR 2008; Nutbeam 2008) and broadening its outcomes beyond the absence of disease (Laverack and Mohammadi 2011). Since its inception at the First International WHO Conference on Health promotion in Ottawa, Canada, in November 1986, it has sparked the conceptualization, development, discourse, and integration of health promotion while inspiring professionals, politicians, and citizens worldwide (Dooris 2013), giving health promoters a sense of identity (Pettersson 2011) and taking on a ‘Holy Grail’ status (McPhail-Bell, Fredericks and Brough 2013).

The Charter provided a strong, holistic vision highlighting interdependency (Porter 2007) while describing health as a resource for everyday living and health promotion as “the process of enabling people to increase control over, and to improve, their health” (Ottawa Charter for Health Promotion 1986). The Charter also paved the way for the settings approach to health promotion (Dooris 2013) and an “active and interactive” comprehension of health (Kickbusch 2007).

Health promoters were presented with various roles and functions which were delineated in the Charter (advocating, enabling, and mediating) and recommended five action areas, which at the time of publication were awaited but also considered quite radical (Scriven and Speller 2007). Areas considered essential for public health action (Kickbusch 2007) included: healthy public policies, supportive environments, personal skills, community action, and reorientation of health services. Building healthy public policy involves advocating for and establishing health as political priorities at all levels and sectors, embracing accountability for health and decision-making impacts on health (WHO 2009; Ottawa Conference Report 1986). The action area “Creating supportive environments” acknowledges the interconnectedness between people and their environment and that people, communities, and the environment need to be cared for and protected with unified, mutual action (WHO 2009; Ottawa Conference Report 1986b). Strengthening community action puts a focus on engaging community resources and strengthening competencies, collaboration, and participation (WHO 2009; Ottawa Conference Report 1986c; Fry and Zask 2016). Developing personal skills is often referred to as health education and health literacy (Fry and Zask 2016). The supplementations of health information and skill development are ways health promoters can care for the personal and social growth of individuals and provide options to foster greater choice and control within environments and towards maintenance of health and wellbeing (WHO 2009; Ottawa Conference Report 1986d; Fry and Zask, 2016). Reorienting health services advocates for a health care system which prioritizes health and requires the shared responsibility and contributions of people, communities, health professionals, organizations, and government (WHO 2009; Ottawa Conference Report 1986e).

The purpose of health promotion was to combine the old public health with a commitment to the new public health, thus creating a synergy between a social determinants approach and individual and community empowerment

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(Kickbusch 2007). Ottawa's vision focused on establishing the norm of partnerships between multiple sectors, upstream measures (addressing fundamental influences on poor health and injustices) (Bharmal, Devose, Felician and Weden 2015), and the engagement and participation of individuals and communities in decisions about their health and wellbeing (Scriven and Speller 2007).

The discourse around the Ottawa Charter and health promotion still continues to circulate within public health and beyond. The challenges and new obstacles that have arisen since Ottawa have prompted initiation of the "Vienna Declaration" launched by the European Public Health Association (EUPHA), which strives to renew the dedication to the principles of the Ottawa Charter for Health promotion by reviewing, updating, and expanding on the prerequisites of health, functions, and action areas (EUPHA 2016). In this context exploring the opinions of health professionals working within health promotion is well warranted. The purpose of this study is to assess the relevance and use of the Ottawa Charter for health promotion today from the perspective of health professionals who are members of the health promotion section within the European Public Health Association (EUPHA). Within EUPHA, public health and health promotion professionals are organized who are typically researchers, health promotion/public health practitioners, or employed in the public health administration, or they work in teaching and education in this field. The main aims of the study were to explore the opinions of such EUPHA-associated health promotion professionals regarding how the Charter and health promotion concepts and practices have been applied in Europe and how the recognition of the field of health promotion is perceived.

Methods

Data collection

The questionnaire study was conducted between April and May 2016. An invitation to participate was sent out to all individuals enrolled as members of the health promotion section of the European Public Health Association, EUPHA ($N = 2400$), in April 2016. A second invitation was sent in May 2016 to all section members to increase participation. Answers were collected from 198 participants, and data from 193 respondents (response rate 8%) were included in the analysis. Characteristics of the respondents are represented in Table 1.

Survey design

The survey questions were developed by the authors on behalf of the EUPHA section health promotion. A pilot test of the questionnaire was executed in March 2016 among 20 health promotion researchers and practitioners to reflect relevant

Table 1 Characteristics of the sample (in valid percentages)

	N	%
Age:		
< 25 years	3	1.6%
25–34 years	35	18.1%
35–44 years	38	19.7%
45–54 years	56	29.0%
55–64 years	46	23.8%
> 65 years	15	7.8%
Gender:		
Female	128	67.0%
Male	63	33.0%
Global region:		
Southern European	54	29.5%
Western European	47	25.7%
Northern European	45	24.6%
Eastern European	19	10.4%
Other	18	9.8%
Professional domain:		
Curative/palliative/health care worker	19	9.8%
Health promotion/public health practitioner/public health administration	72	37.2%
Researcher and/or teaching/education	102	52.8%
Length of time working in public health/health promotion:		
< 5 years	29	15.0%
5–15 years	66	34.2%
16–30 years	75	38.9%
> 30 years	23	11.9%

feedback. The participants were asked questions related to socio-demographics and professional characteristics including age and gender, one's country of reference for their work as a health professional, and the number of years working in the field of health promotion/public health. The participants were asked what type of professional domain they identify with, and the three answering options were: researcher, health promotion/public health practitioner or public health administration, and teaching/education. For the analysis, the categories "Researcher" and "Teaching/education" were collapsed into "Researcher and/or teaching/education". Reference countries were then divided into six global regions according to WHO while European countries were divided into Northern, Southern, Eastern, and Western Europe according to the United Nation's geoscheme for Europe (<https://unstats.un.org/unsd/methodology/m49/>). A total of 18 respondents were from countries outside of Europe, namely Australia (1), Brasil (1), Canada (4), Egypt (1), Indonesia (1), Israel (6), Nigeria (2), and Taiwan (2). Participants were asked to reflect on their perceived progress in health promotion since the Ottawa Charter's development 30 years ago and to state the level to which they agreed or disagreed with various

statements. The content of statements is shown in Table 2, and five category options were provided to identify with the statements: "strongly agree," "agree," "unsure," "disagree," and "strongly disagree." For the analysis, "strongly agree" and "agree" were collapsed into one category, "unsure" was independent, while "strongly disagree" and "disagree" were collapsed into another category resulting in a total of three categories.

Perceived use of the Ottawa Charter action areas in the respondents' respective country was evaluated with a series of questions. Respondents were asked to reflect on the five action areas of the Ottawa Charter (developing healthy public policy, creating supportive environments, strengthening community action, developing personal skills and knowledge, re-orientation of health services). For each action area, a rank of five options was presented to respondents to categorize perceived use: I do not know, never used, sometimes used, used regularly, and used very often. Further analysis collapsed "used regularly" and "used very often" into one category.

Ethics and confidentiality

All participants were informed that participation was voluntary and that the data were collected pseudo-anonymously and treated confidentially. Data of participants were treated according to the data protection legislation.

Statistical methods

Descriptive statistics were conducted in STATA 14.0. Chi-square tests were conducted to determine the measures of association between certain variables such as global region and professional domain with perceived applicability of each of the five actions areas.

Results

Characteristics of the respondents

The majority of respondents (90.6%) were in the age of working life between 25 years and 64 years, and 85.0% have ≥ 5 years of work experience in the field of public health/health

promotion. Two thirds of respondents were females (67.0%). While respondents from Northern, Western, and Southern European regions were fairly evenly represented, only 10.7% of respondents were from Eastern European countries and 9.8% from outside of Europe. Most of the respondents identified themselves as belonging to the category "researcher and/or teaching/education" (52.3%) followed by "practitioners/administration" (37.2%), while only 9.8% identified themselves as "curative/palliative/health care worker" (Table 1).

Perceived progress of health promotion

As shown in Table 2 43.7% of respondents agreed that the field of health promotion is well established in their country. When asked whether they felt that health promotion was well established in Europe, 50.0% agreed. Although 80.0% of survey participants felt that the topic of health promotion has progressed over the past 30 years, 80.7% also felt that the topic of health promotion is in need of a deeper reflection since the development of the Ottawa Charter.

Frequency of use of the action areas

When participants were asked to rate the perceived use of the five Ottawa Charter action areas in their reference country, the percentage of use was rated highest for "Developing personal skills and knowledge" at 63.2% followed by "Developing healthy public policy" at 44.8%, with the rate slightly dropping for "Strengthening community action" at 40.7%, declining to 37.0% for "Creating supportive environments" and lowest for "Reorientation of health services" with 30.5% (Table 3).

The use of the five action areas was generally rated highest among Northern European participants and among those from outside Europe (others) and lowest among Eastern and Southern European participants. The difference in ratings between countries was only significant for "Strengthening community action" and "Creating supportive environments," where only about 10% of the participants from Eastern European countries stated use of the action in their reference countries, while this was the case for at least 28% of respondents from the other regions (Table 3).

Table 2 Perceived progress of health promotion among survey respondents ($N = 193$)

Statements	Agree (%)	Disagree (%)	Unsure (%)
Since the development of the Ottawa Charter in 1986, the field of health promotion is well established in my country	43.7	30.0	26.3
After 30 years of the Ottawa Charter, the field of health promotion is well established in Europe	50.0	17.9	32.1
Overall knowledge about the topic of health promotion has progressed over the past 30 years	80.0	9.5	10.5
The topic of health promotion requires deeper reflection since the development of the Ottawa Charter	80.7	5.7	13.5

Table 3 Frequency of perceived use of Ottawa Charter action areas in their respective countries (in valid percent) in total and by region and professional domain

Global region	Healthy public policy		Supportive environments		Strengthening community action		Developing personal skills		Reorientation of health services	
	N	%	N	%	N	%	N	%	N	%
Total <i>N</i> = 182	82	44.8	67	37.0	74	40.7	115	63.2	56	30.3
Geographical regions										
Southern European <i>N</i> = 54	24	44.4	15	28.3	17	31.5	27	50.0	14	25.9
Western European <i>N</i> = 47	17	36.2	18	38.3	20	42.6	35	74.5	16	34.0
Northern European <i>N</i> = 45	24	53.3	22	48.9	24	53.3	32	71.1	16	35.6
Eastern European <i>N</i> = 19	8	42.1	2	10.5	2	10.5	10	52.6	4	21.1
Other <i>N</i> = 17	9	50.0	10	58.8	11	64.7	11	64.7	6	35.3
Professional domain										
Curative/palliative/ health care worker <i>N</i> = 19	10	52.6	6	31.6	9	47.4	9	47.4	4	21.1
Practitioner/public health administration <i>N</i> = 70	26	36.6	23	32.9	27	38.6	45	64.3	21	30.0
Researcher and/or teaching/education <i>N</i> = 101	49	48.0	42	41.6	42	41.6	67	66.3	33	32.7
<i>P</i> value (chi ² test between professions)	0.245		0.439		0.778		0.286		0.597	
<i>P</i> value (chi ² test between regions)	0.559		0.008		0.003		0.068		0.677	

The perceived use of the five actions areas in their respective countries did not significantly differ by professional domain. Rather the frequencies reflect a relatively high use of strategies to develop personal skills and a low perceived implementation of reorientation of the health system (Table 3).

Discussion

This study investigated how the Ottawa Charter and health promotion concepts and principles have been applied across European regions and professional domains in the perspective of health promotion professionals. Regarding the perceived use of action areas in the health promotion field, "Developing personal skills and knowledge" (64%) was rated most frequently and regularly used in one's country among participants, the highest among Western (75%) and Northern Europeans (71%) and lowest for Eastern (53%) and Southern Europeans (50%). The relatively high perceived use of educational strategies may be explained by the fact that this action area is relatively broad in potential impact with its core ideas as supplementing information, health education, and the enhancement of life skills (Ottawa Charter for Health Promotion 1986), which include many possibilities for usage. As McQueen and De Salazar (2011) explain, information can be an inactive concept, education is about broadening one's knowledge, and skills are a means that allow an individual to undertake certain actions. As a result, developing personal

skills can include a wide range of initiatives. Furthermore, as pointed out by Weare et al. (1992), before the Ottawa Charter health education had already gained ground in various countries, particularly in the school setting. Therefore, existing methods, examples, and channels were likely available and easier to apply than some of the other action areas.

Though sharing health information and education has been shown to be an area with a fair amount of use in all geographic regions, the Vienna Declaration (2016) describes the current challenge is now the overload of information as well as misinformation that is now quickly accessed by citizens (EUPHA 2016). Managing this will require creative strategies from health promoters and the public health community as well as gaining the trust and respect of the public to continue sharing and disseminating credible knowledge and skills. It is somewhat a paradox that the Ottawa Charter was created initially in response to a heavy focus on individual approaches (Thompson et al. 2017) and that—as our data indicate—after 30 years the area "Development of personal skills" still seems to play the predominant role. One potential reason for this lack of a substantial shift in focus of health promotion action towards more upstream measures which was warranted by the Ottawa Charter might be the tendency within societies with mostly neo-liberal governments to withdraw from welfare in the 1990s, which has resulted in prioritizing more individualistic lifestyle approaches (Wills and Douglas 2008).

However, it might be attributed to the Ottawa Charter and its influence in the respective countries that as second-most

common, "Developing healthy public policy" was declared as used by 44% of respondents with the highest percentage among Northern Europeans (53%) and the lowest among Western Europeans (36%), although the differences between regions were not significant. In agreement with our results, others state that over the past 30 years, more attention has been given to this domain in recent years and that stakeholders interested in health are increasing (Kickbusch 2010). Although there have been good examples of policies that aim at risk factors and disease reduction, there is also concern that comprehensive national policies that integrate actions to improve health and social and economic conditions across sectors are still rarely seen (IUHPE and CCHPR 2008).

As the next most common area, 41% of participants rated "Strengthening community action" as often used, with significant differences between regions showing the highest ratings for Northern Europeans (53%) and the least for Eastern Europeans (11%). The struggle in using this domain can be in part due to its complexity, which may focus on a different purpose or require engagement in various stages at different times such as participation, or becoming concerned with building on competencies and capacities, and is directed toward specific goals and actions (Laverack and Mohammadi 2011). At another stage, strengthening community action may be assisting communities to solve issues related to their lack of power and locating or using their voice to be more politically active. This has been considered to be the catalyst for empowerment (Laverack and Mohammadi 2011), a term which, though explored in this domain, is often elusive with its absence of concrete methodologies and strong evidence in diverse settings and cultural environments (Laverack and Wallerstein 2001). Furthermore, it is possible that its reliance on reorientation of health services and professional practice as well as the political climate that influences practitioners, communities, approaches, and agendas (Laverack and Mohammadi 2011) can further complicate the use and feasibility of this action area.

Next, only 36.3% of survey participants perceived "Creating supportive environments" to be often used with significant difference between regions with again the highest ratings among Northern Europeans (49%), followed by Western (38%) and Southern Europeans (28%) and 11% among Eastern Europeans. The relatively low use of this action area is in contrast to the IUHPE and CCHPR (2008) stating that settings-based initiatives should be cultivated as health-promoting workplaces and schools tackle health determinants and behaviors. It is evident that in Europe and beyond, since the Ottawa Charter a plethora of international and national programs and networks have emerged, covering settings as diverse as regions, districts, cities, islands, schools, hospitals, workplaces, prisons, universities, and marketplaces (Dooris 2006). This can be considered major progress, but the influence is not as strong as it could have been according to Dooris (2006), and concerns exist about whether a consequence of a

settings approach may at times result in fragmentation as settings operate at different levels (Dooris 2006).

Only 31% of survey respondents felt the action area "Reorientation of health services" was often used and 10% perceived it to never be used at all, without any significant differences between regions. This is not surprising as merging health promotion to the mainstream requires the investment, value, and collaboration of various stakeholders at local, regional, and global levels (Ziglio, Simpson and Tsouros 2011). Wise and Nutbeam (2007) assert that this action area has had minimal systematic attention as its own action area and with respect to the four other action areas and is still an unaccomplished agenda. Ziglio et al. (2011) state that part of this requires the reframing of messages. Also, Johansson and co-authors (2010) observed that though there may be willingness among health professionals in their Swedish sample to engage in more health promotion and disease prevention in primary care and hospital settings, several barriers such as high workload have made this challenging.

This study did not find any particular difference in ratings between respondents working in curative or practice settings compared with those in public health administration or in research, but differences according to European regions emerged. With the exception of "Developing personal skills", the perceived use of action areas in one's geographical region was in the order of Northern Europe, Western Europe, Southern Europe, and Eastern Europe, with "Community action" and "Supportive environments" being particularly low for Eastern Europeans. Though no conclusions can be drawn in this descriptive study, this pattern may give insight to the state of health promotion and public health progress and practice in these regions. Responses from a survey studying differences in public health research among Northern, Southern, and Eastern Europe indicated that health services, health promotion, prevention, and education were indeed priorities at a national level in countries identified as Northern and Western Europe in our study (Mannoci, Ricciardi and La Torre 2009), but infrastructures and technology shortages were identified barriers in Southern and Eastern Europe compared with the North (Mannoci et al. 2009).

Though the action areas are looked at individually in our study, one must keep in mind that they are designed to interconnect, which may impact their separate and overall use. However, as Ziglio et al. (2000) point out, most health promotion activity has continued to be issue-based or else has focused on only one determinant at a time. Therefore, health promoters should also be conscious of designing interventions to actively target more than one action area at a time, recognizing and demonstrating that each domain is mutually dependent on another, and achieving a major impact on the determinants of health or policy development (Ziglio et al. 2000).

A total of 72% of participants felt that health promotion sparks interest and engagement among health professionals

and policy makers. This is a promising result as increased value for health promotion among stakeholders and the public is necessary to increase its demand. Such a demand is relevant in order to avoid that health promotion occurs infrequently rather than an essential service (Johansson et al. 2010). Also promising is the results that 72.5% of respondents felt that health promotion is a necessary field, and 80% agreed that overall knowledge about the topic of health promotion has progressed over the past 30 years. This is in line with the findings from Ziglio et al. (2000) who state that the implementation of a wide range of health promotion initiatives has generated much collective experience within Europe and added considerably to both knowledge and progressive change.

On the other hand, less than half (44%) of the participants felt that the field of health promotion was well established in their country, and only 50% felt that it is currently well established in Europe. Though there have been well-known health promotion innovations in the European region since the Ottawa Charter, with the Investment for Health Approach, Healthy Cities, Health-Promoting Hospitals, and Health-Promoting Schools, to name a few, in agreement with our results, there is evidence that the overall impact of these innovations has been relatively limited in the region (Ziglio et al. 2000). It has been argued that the various social, political, and economic changes unfolding in European society parallel to the growth of health promotion have limited the impact of health promotion in different settings (Ziglio et al. 2000).

This study has limitations, as it only captures subjective perspectives regarding the relevance and use of the Ottawa Charter action areas but is unable to measure implementation in the European region. Other research aiming at quantifying implemented programs and actions in the different areas for European countries would be needed for this. Though this study indicates its focus on the European region and surveyed professionals connected to EUPHA, voices and perspectives of other countries are not captured, particularly in developing regions. The limited number of respondents ($n = 18$) from countries outside of Europe does not cover other relevant geographical areas. Therefore, the study widely excludes valuable perspectives on how useful or relevant the Charter has been outside of Europe. Furthermore, it excludes perspectives of those who are not yet experts or professionals, such as students or lay people. In addition, since only 8% of the health promotion section members responded to the survey invitation, the responses do not necessarily represent all section members. Furthermore, due to the limited sample size of respondents from some geographical regions, especially of those from Eastern European countries, the results regarding geographical variation need to be interpreted with caution. In the spirit of democracy, future reflections on the Ottawa Charter should seek to explore perspectives of the Ottawa Charter and its relevance from professionals outside of Europe and in developing regions as well as among non-

experts. The Charter is a powerful document which should not only circulate and be analyzed within the public health community.

Though the Charter sparks motivation and hope, particularly at its conferences, a Charter with misplaced action, agreement upon, and advocacy for its principles will simply remain a Charter. Though progress has been made over 30 years, the unfulfilled potential coupled with emerging health threats may help to explain why 81% of participants in this study felt that the topic of health promotion requires deeper reflection since the development of the Ottawa Charter. It is undeniable that over the past 30 years global changes and challenges have emerged that require updated strategies to address new threats such as commercial determinants of health and non-communicable diseases, to name a few. However, as Thompson and others (2017) point out, the Charter was created in response to a heavy focus on individual approaches, which is recently a returning problem along with other challenges such as access to water or health for all, for example. The Ottawa Charter continues to be a relevant concept as its vision highlights relevant issues that have yet to be resolved and presents roles for health promoters yet to be fulfilled and action areas yet to be optimally implemented.

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Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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