Global Health Promotion

Preface

"Visioning the Future of Health Promotion: Learning from the past, shaping the future"

Liane Comeau[1] and Marie-Claude Lamarre[2]

> "A commemoration is not a point of arrival: it can only be a pause encouraging constructive reflection and mixing in the same dynamic a future-oriented assessment with a prospective rooted in the past." (1)

When we celebrate an anniversary, we celebrate a date, that of a birth, a foundation, a marriage, a death. It is indeed an anchor point and a reference in time that refers to a person, an institution, or an event, to the continuity of history, and that brings us together. As far as we are concerned, we are celebrating an institution that matters in a community and in our world.

This year we celebrate the 70th anniversary of the creation in Paris, in May 1951, of the International Union for Health Promotion and Education (IUHPE). This is an exceptional moment to reaffirm our commitment to a more equitable world and to take an optimistic look at the future of health promotion. We celebrate values, principles – mainly social justice and equity, diversity, the power to act on one's own health and that of one's community – as well as working in partnership. This brings us together in health promotion and makes us recognize each other in a public health space that is increasingly tangled with more or less consensual concepts, theories, and practices.

We celebrate the unique contribution of health promotion as a response to the challenges of our societies at all levels – local, regional, national, or international – with respect and in the complementarity of the respective roles and missions of the political, academic, and practice circles. Intersectoral work for health and well-being, moreover, seems increasingly relevant in a complex world where health depends on multiple factors.

This edition of *Global Health Promotion* and the quality of the content of this special issue make a wonderful birthday present to IUHPE, its members, and the readers of its journal. By combining the perspectives of several generations of thinkers, researchers, and practitioners, it conveys the sense of a "family reunion," that of members and partners close to the history and evolution of the IUHPE, which brings together health promotion leaders and visionaries who have served it well, and representatives of new generations. This special issue offers a reflection on ways to further the advancement of health promotion around the world in terms of research, practice, and public policy development.

As we all know, there is not one single universal conception of health promotion, but a pluralist conception that is part of a history of public health, within local political, cultural, social, and economic conditions and systems. What creates the link between these visions is that there is a consensus on how to approach health as a social enterprise through a set of joint strategic activities to achieve the same goal, including advocacy, education, training, research, legislation, policy coordination, and community development, regardless of the problems to be solved, the populations concerned, and the contexts and life settings.

Another common link is that of targeting the multiple determinants of health and linking health achievements to structural adjustments made through political, economic, environmental, and social change. In this regard, the current discourse on climate change and its impact on people, as well as the United Nations Sustainable Development

1. Executive Director of IUHPE, Montreal, Quebec, Canada.
2. Former Executive Director of IUHPE, Paris, Saint-Maurice, France.

Correspondence to: Liane Comeau, Executive Director of IUHPE, c/o École de Santé Publique, Université de Montréal, 7101 avenue du Parc, Montreal, QC H3N 1X9, Canada. Email: lcomeau@iuhpe.org

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Goals, provide anchors to act on all determinants of health in a coordinated and systemic manner while leaving no one behind. The COVID-19 pandemic we are currently experiencing also highlights the weaknesses of our societies and underscores the importance of systemic approaches to closing gaps to support the health and well-being of all.

We are, therefore, celebrating 70 years of participation and learning, of shared reflection on the role and meaning of health and health promotion in our contemporary societies, of innovation, of trials-and-errors, and of achievements. There is no doubt, however, as to the relevance of health promotion, its approaches, and methods, to meet the challenges of the present and the future.

We celebrate 70 years of collaborations, and of relationships that will survive us through the transmission and dissemination of ideas, knowledge, and experiences. Our complementarity is a guarantee of efficiency in the pursuit of our common objectives. Being part of the IUHPE means being part of an engaged community. Participating in its projects, events, and outreach is to have the privilege of working alongside the best, exchanging with them and learning from them. The IUHPE exists and has assets only through that of its members, and through its diversity of knowledge and practices accumulated over the years. This global community of individuals and institutions is open, inclusive and welcoming new members on an ongoing basis.

This special issue of *Global Health Promotion* measures progress and also highlights the major issues at stake for health promotion that continue to nurture many debates: the enhancement and the recognition of our domain and field of action; its inclusion in the culture; the complexity of the organization of health promotion within the policy framework and from a systemic perspective; as well as the need for training at all levels, in order to reconcile discourse and actions and to build new generations of qualified, competent, and motivated actors.

May this edition contribute to paving the way for new perspectives and societal projects based on evidence accumulated over the years from all parts of the world!

Reference

1. Aujoulat L.-P. *A Long Way To Health Promotion Through IUHPE Conferences 1951-2001*. Editors Maria Antonia Modolo and Joyce Mamon. Interuniversity Experimental Centre for Health Education. University of Perugia.

"Visioning the future of health promotion: learning from the past, shaping the future"

Margaret M. Barry

It is my honour to serve as guest editor for this special publication to mark 70 years since the foundation of the International Union for Health Promotion and Education (IUHPE). This anniversary special issue provides an opportunity to critically reflect on the evolution and future development of health promotion and to consider IUHPE's role in advancing the field now and into the future.

The 'International Union for Health Education' was officially launched in 1951. This international non-governmental agency was founded by Professor Jacques Parisot, Professor of Public Health in the Medical School in Nancy, France, and Mr Lucien Viborel, Director of the National Centre for Health Education at the Ministry of Public Health in France. The French Government promoted the organization of the Constitutive Assembly of the Union in May 1951 at an international conference in Paris. This was a time of great change in the aftermath of the Second World War, which highlighted the urgent need for global cooperation. The United Nations was founded in 1945, including setting up the World Health Organization as a specialized agency responsible for international public health with the aim of promoting and protecting the health of all peoples. The establishment of the International Union just a few years later was a long-sighted and strategic development, with the realization that a global movement of people and organizations committed to promoting population health was needed to accompany the vision and work of global agencies such as the World Health Organization. Over the last 70 years the International Union has grown and developed its core mission, embracing Health Promotion in its title in 1993 to become IUHPE. Since then it has developed and expanded its role as an independent global professional association dedicated to advancing health promotion and health equity. As a unique membership-based NGO, IUHPE remains strongly committed to its founding principles while also keeping a strategic focus on the innovation and transformation that is needed to advance global health promotion over the next 70 years.

To mark the 70th anniversary, this special publication brings together a collection of papers, commentaries and perspectives on the past, present and future of health promotion. Critical insights are exchanged on health promotion's role as a key transformative strategy for advancing human health, wellbeing, equity, and sustainable development in the face of global challenges. The papers also critically consider IUHPE's role in strengthening health promotion globally, working with members and partner agencies in advancing policies, practices, structures, capacities and research that will promote population health, health equity and wellbeing and a healthier and sustainable future for all.

The first set of papers provide critical reflections on the current state and development of health promotion from a policy, research and practice perspective. In my own paper (Barry), I consider how transformative health promotion can be advanced, and critically reflect on what progress needs to be made and the structures and processes that are required to strengthen health promotion at a systems level. The enabling mechanisms that are needed at a conceptual, policy and implementation level to strengthen health promotion systems are discussed and the critical role of IUHPE in this endeavour is outlined. The paper by De Leeuw and colleagues charts the development of policy in health promotion and introduces the concept of a health political science for health promotion. Case studies are presented to illustrate the value of applying health political science theorizing to health promotion. The authors call for a greater appreciation of the political nature of the field and for deeper insights into the

President of IUHPE, Professor, National University of Ireland Galway, Ireland.

Correspondence to: Professor Margaret M. Barry, President of IUHPE, World Health Organisation Collaborating Centre for Health Promotion Research, National University of Ireland Galway, University Road, Galway, H91 TK33, Ireland.
Email: margaret.barry@nuigalway.ie
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conceptual grounding of health promotion policy processes. Potvin and Jourdan consider the state of development of health promotion research. They argue that while health promotion research is a distinct field of research, it currently lacks a unifying framework to structure its knowledge base. They propose three structuring pillars that build on existing health promotion research practice – the object, purpose and nature of the knowledge generated from health promotion research – and outline current work that offers a direction for the structuring process. Van den Broucke's paper addresses the continuing development of health promotion practice as a transdisciplinary field within public health. This paper outlines the unique contribution of health promotion to public health and discusses the importance of workforce development based on core competencies for health promotion practice. Van den Broucke considers how health promotion capacity development can be strengthened in the context of integrating health promotion within the practice of public health. The focus on workforce capacity development is continued in a commentary from Battel-Kirk and colleagues, where they report on the development and implementation of the competency-based IUHPE Accreditation System as a quality assurance system for global health promotion practice, education and training. An overview is provided of how the Accreditation System works and its current status, and research on its impact on workforce development is presented and future plans discussed.

The next set of papers consider future directions and priorities for health promotion in the 21st century, taking into account current and future challenges. A series of papers and commentaries discuss new approaches and emerging ideas to re-envision health promotion's role. Nutbeam's commentary considers the relationship between health education and health promotion and, applying the lens of health literacy, considers how building on the past can shape the future. Nutbeam outlines the challenges and opportunities presented by new digital health technologies in enabling people to access and engage with health information and set health goals. The paper discusses the role of skills-focused health education and the importance of interactive and critical health literacy in engaging with digital media, supporting empowerment, community development and social activism for health.

Kickbusch in her commentary on visioning the future of health promotion outlines transformative approaches to promoting health and wellbeing. She argues that the way forward for health promotion must be framed to address the challenges of our time, including inequality, climate crisis, pandemics, digitalization and a weakening democracy. She considers new models and approaches and discusses how embracing complexity, the transformative metrics of wellbeing, and the design of supportive environments will allow societies to benefit from integrated policies that promote health, wellbeing and sustainability.

Baum's paper considers how health promotion can be reframed to address the current crises of growing inequities, a warming planet, the pandemic and a fracturing of trust and solidarity in societies. The paper discusses the need to take planetary health more seriously, including the importance of using systems thinking; determining the role of health promotion in governing for health and health equity; and how to balance health promotion as a profession with being a social movement. Baum calls for a more radical health promotion agenda that can achieve the goal of a healthy, equitable and sustainable planet in which all humans can flourish.

The theme of planetary health is further detailed in a paper by Tu'itahi and colleagues which addresses the question: 'how do we improve the health of the population – especially the health of the most disadvantaged and vulnerable – while making peace with the Earth?'. This paper provides an overview of global ecological changes being driven by social and economic forces and considers their health implications. The Legacy Statements of the IUHPE 2019 World Conference on Health Promotion are discussed and the authors call on health promoters to provide leadership in promoting a new set of values that are compatible with planetary health, drawing on Indigenous and spiritual perspectives, and addressing both the ecological and social determinants of health. The commentary that follows from Magistretti and colleagues discusses the role of grassroots movements in planetary health and considers how the discourse on grassroots activism can be reframed as a global salutogenic process of change. The People-Planet-Health project is presented as a novel knowledge exchange initiative, which aims to give voice and visibility to grassroots groups.

The authors call on health promotion practitioners and global policymakers to recognize and value the contribution of grassroots movements in the creation of planetary health.

Ottemöller and colleagues from the IUHPE International Student and Early Career Network address health equity and explore how the theory of salutogenesis can re-envision health promotion with marginalized communities. The paper outlines the need to acknowledge the deep-rooted and historical causes of health inequities, including the influence of colonial and Western ideologies. A radical change in current approaches is proposed with a shift in focus from pathologizing traditionally oppressed communities to a community engagement and participation approach, building on traditional and indigenous knowledge, that promotes the resilience and wellbeing of marginalized communities. We conclude this section with two commentaries on progressing the Sustainable Development Goals (SDGs) in the African and South-East Asian regions. Munodawafa and colleagues consider health promotion in the African continent, outlining current regional strategies and developments in respect of progressing the SDGs. The specific challenges and opportunities for health promotion, including addressing the current COVID-19 pandemic, are discussed and recommendations are made for strengthening health promotion policy and practice, placing it at the centre of the development agenda in order to achieve the SDGs in the region. Mukhopadhyay and Kaur outline the situation in South-East Asia and consider the importance of investing in health promotion to achieve the SDGs. They discuss the development of health promotion in the region and the overriding importance of addressing the social determinants of health, especially for populations living in conditions of economic and social deprivation.

We close the special issue with a series of perspectives from five of the past Presidents of IUHPE, who share their personal reflections and provide fascinating insights on the development of health promotion and IUHPE over the last 20 years and consider future developments.

I am extremely grateful to all the authors and reviewers who contributed to this special issue and to the Editor-in-Chief, Professor Erica Di Ruggiero, and IUHPE Head of Scientific Affairs, Dr Ana Gherghel, for their work in making this possible. I also wish to acknowledge the contribution of all the staff and members of IUHPE, past and present, and all who have supported the work of the organization since its foundation. IUHPE has been a consistent voice for health promotion across the years and has provided a vital platform for unifying the global network of people and agencies dedicated to advancing the field. We are at a critical time in marking this 70th anniversary, as we navigate our way through the pandemic, aiming to build back better and fairer, and plan for a healthier future for all. Health promotion has to be at the forefront of this endeavour, placing the promotion of health equity at the centre of the health, wellbeing and sustainable development agendas. The full potential of health promotion has yet to be realized and now, more than ever, transformative health promotion actions need to be put in place. We know what works and now is the time to put effective strategies into action. IUHPE will continue to support this global effort, advocating for health equity and supporting the global community of health promoters to unite in strengthening health promotion and its implementation in practice over the next 70 years. I hope you enjoy reading this special issue and that you will join us in celebrating the 70th anniversary. May IUHPE stay forever young!

Original Article

Transformative health promotion: what is needed to advance progress?

Margaret M. Barry

Abstract: Transformative health promotion actions are needed to achieve health equity and the Sustainable Development Goals (SDGs), advance human and planetary wellbeing, and ensure that we build back better post-COVID-19. Health policies and systems need to be aligned with the values, principles and strategies of health promotion and investment made in strengthening essential health promotion functions. This paper considers how transformative health promotion can be advanced, by reflecting critically on what progress needs to be made and the structures and processes that are required to strengthen health promotion at a systems level. Progress in implementing health promotion is variable, and there is a general lack of investment in developing the necessary health promotion systems for substantive progress to be made. Key enablers and system requirements for comprehensive health promotion are examined, including the following critical elements: (i) effective advocacy for the concept and practice of health promotion; (ii) enabling policy structures for universal health promotion actions on a cross-sectoral basis; (iii) effective implementation systems, support mechanisms and workforce capacity for multisectoral health promotion action; (iv) investment in innovative research methods and knowledge translation to inform transformative health promotion approaches. In strengthening capacity to implement transformative health promotion actions, political will needs to be mobilized to ensure that dedicated and sustainable funding is made available, and the organizational and workforce capacity to deliver effective health promotion interventions is in place. The International Union for Health Promotion and Education (IUHPE) plays a central role in advancing transformative health promotion through mobilising and supporting its global members and partners in strengthening health promotion systems.

Keywords: Transformative health promotion, health promotion systems, enablers and system requirements

Introduction

Transformative health promotion approaches are needed to advance population health and wellbeing and address current and future challenges to global health and wellbeing. Achieving the goals of global health strategies (1) and the United Nations (UN) Sustainable Development Goals (SDGs) (2) calls for responsive and flexible health systems and approaches that can move beyond a focus on curative health care to deliver population-based strategies that will ensure healthy lives for all, address the broad determinants of health, and place empowered people at the centre of their own health and wellbeing. Investment in health promotion has the potential to bring transformational change in how population health is understood, and expand the range of innovative mechanisms and strategies that can be used to promote health and wellbeing, and reduce health inequities.

The scale of the COVID-19 pandemic and its impact on people's health, and their social and economic lives, has highlighted the urgent need for comprehensive multisectoral responses that can

World Health Organisation Collaborating Centre for Health Promotion Research, National University of Ireland Galway, Ireland.

Correspondence to: Margaret M. Barry, World Health Organisation Collaborating Centre for Health Promotion Research, National University of Ireland Galway, University Road, Galway, H91 TK33, Ireland. Email: margaret.barry@nuigalway.ie

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address the upstream drivers and consequences of health challenges. The need for responsive public health systems is thrown into sharp focus, in particular the critical role of health-promoting social and behavioural interventions, and the importance of effective coordination and collaboration at a country and global level. The pandemic has exposed systemic failures to invest in health infrastructures, particularly those related to multidisciplinary public health and health promotion. The inequities and structural deficiencies exposed in the capacity to respond to the pandemic calls for a profound, structural and sustained transformation of health systems (3). Health promotion must be at the centre of this transformation to ensure that the underlying causes and effects of health challenges are addressed. This entails placing a greater focus on population-based interventions and community empowerment strategies that can increase people's control over their health, reduce health risks and inequities, enhance social cohesion and community solidarity, and create supportive environments for sustainable population health and wellbeing. Health promotion interventions at a community and population level have been shown to be critical in addressing the health challenges of NCDs and other infectious diseases, improving mental health, and addressing the social determinants of health and health equity (4,5). It is time to address the chronic lack of investment in health promotion in order to ensure that systems and processes are put in place that can deliver transformative health promotion actions for long-term change in an evidence-informed, integrated, and sustained fashion.

This paper considers how transformative health promotion can be advanced, by reflecting critically on what progress needs to be made, and what structures and processes are required to strengthen health promotion at a systems level. The enabling mechanisms that are needed at a conceptual, policy and implementation level to strengthen health promotion systems are discussed.

The need for transformative health promotion action

Addressing current and future health challenges

The rationale for health promotion is as compelling today, if not more so, than it was when it emerged as a dynamic new force within public health in the 1980s (6). The complexity of current threats to health and wellbeing, with the most disadvantaged in society bearing the greatest burden, means that transformative action is urgently required to make measurable progress. Addressing the broad and complex nature of the challenges presented by increasing health inequities, infectious diseases, noncommunicable diseases (NCDs), mental health challenges, humanitarian crises and planetary health requires a transformation of public health systems and approaches. Treatment approaches and vaccines alone are not sufficient to eradicate diseases. Comprehensive population-based approaches are required to bring about the scale and scope of changes needed for sustainable health improvement at a population level. Supportive policy measures focused on strengthening health promotion are required to ensure effective action across governments and society that will lead to more equitable health outcomes.

Strengthening the capacity of health systems to deliver on improved population health and wellbeing means reorienting health policy and systems to focus on creating the environments, structures and processes that shape the development of good health at a population level. Strengthening health promotion is an effective and efficient means of enhancing people's mental and physical health and ensuring their social wellbeing across the life course. A narrow focus on disease-oriented health care and treatment on its own is unsustainable financially, and will not achieve the necessary improvements in population health (7,8). A fundamental shift in focus from disease to health in our health systems is needed. This entails transforming existing organizational structures, resources, workforce and services toward promoting population health and wellbeing and integrating health promotion across the health system. The practical implementation of health promotion will improve the performance of health systems and strengthen their capacity to improve population health and reduce health inequities, both of which are key to realization of achieving health for all and ensuring that we build back better post-COVID.

Reducing health inequities

Delivering on the UN SDGs (2) and universal health coverage (UHC) (9) calls for a renewed focus

on a determinants of health approach, and for prioritization of policies and strategies that can address the social, economic, commercial, cultural and environmental determinants of health. Addressing the structural determinants of health requires change at the level of social policies and systems in order to reduce poverty, improve living environments and working conditions and ensure equity in access to resources and services, alongside changes in societal norms and values that will tackle structural racism and discrimination and promote social justice. Closing the health equity gap calls for comprehensive action based on a whole-of-government and whole-of-society approach (10). An integrated policy approach is integral to effective action, entailing multisectoral action across governments, civic society and international organizations to ensure healthy lives and sustainable living environments (11).

Achieving intersectoral action for health is, however, challenging as it requires political will, coordinated action and structures to advance cross-sectoral policy development and implementation. A 'health in all policies' approach (HiAP) (12) emphasizes intersectoral actions across government and society and calls for new models of working, including effective intersectoral structures and processes, participatory processes and partnership working. However, a HiAP approach has been implemented comprehensively in only a handful of countries, and the intersectoral policy systems and structures necessary to support its implementation are lacking in most countries.

Health promotion as a transformative strategy for advancing wellbeing

The growing focus on wellbeing (13), and the creation of wellbeing budgets in some countries, has brought the wellbeing agenda into the centre of the policy making process in governments. The UN Political Declaration Rio+ Summit (14) committed member states to improving the wellbeing of the planet and its inhabitants going beyond a focus on gross domestic product as the sole indicator of a country's growth and development. The wellbeing agenda guides policy towards a more holistic vision of human development and a more integrated approach to growth and social progress. A positive wellbeing focus calls for new policy frameworks and a re-thinking of social, economic and ecological policies and their impact on wellbeing and human flourishing (15).

Promoting mental wellbeing was explicitly referenced for the first time on the UN sustainable development agenda in 2015, thereby acknowledging that good mental health is central to ensuring healthy and flourishing lives for all, and contributes to achieving a wide range of health, social, economic and development outcomes. Frameworks for population mental health promotion clearly endorse the central role of intersectoral actions across governments and society in creating the conditions that will create and promote positive mental health and reduce mental health inequities (16), including those exacerbated by the COVID-19 pandemic (17). Effective and feasible population-based mental health promotion interventions have been developed that can be implemented across the lifecourse and across key settings (18). However, these comprehensive universal strategies require an enabling policy structure, processes and capacity to ensure that they can be implemented in a sustainable manner.

The enablers of transformative health promotion

From rhetoric to transformative actions

While many global health policies and strategies are aligned with the goals of health promotion, political commitment to implementing health promotion is still lagging in many countries. Health systems and budgets remain focused primarily on curative and clinical care (19), and there has been a lack of long-term investment in health promotion in most countries. Re-balancing the prioritization of treating and preventing disease over the promotion of longer-term health improvement is difficult to achieve, especially when health funding and resources are under pressure. Health promotion interventions have been shown to be cost-effective in improving population health, reducing risks for NCDs, improving mental health and addressing the determinants of health (5,20,21). However, implementation gaps exist in policy and practice, and this combined with a lack of funding and political commitment results in a failure to implement health promotion and thereby a failure to realize its full potential. This represents a lost

opportunity with significant consequences in terms of diminished levels of health and wellbeing, avoidable illness and suffering, and broader social and economic impacts (22).

The Ottawa Charter (6) put health promotion on the policy agenda of many countries. While some countries have made good progress in establishing the necessary infrastructure for implementing health promotion policies and actions, progress generally has been characterized as lacking political commitment, with significant challenges remaining in integrating health promotion as a core plank of modern health systems (23–25). Approaches such as healthy settings have been successfully implemented in a number of countries globally (26). However, the level of infrastructure and capacity to support and sustain integrated health promotion varies considerably. Capacity mapping exercises across high-, middle- and low-income countries (27,28) suggest that health promotion systems are poorly developed and underfunded in most countries and there is a limited appreciation of the infrastructure, resources, knowledge and skills that are required to translate health promotion into action. As a result, there are significant implementation gaps and a lack of investment in the necessary health promotion systems for substantive progress to be made.

What is needed to advance progress?

Advancing progress calls for renewed efforts in prioritizing health promotion on the policy agenda and ensuring effective structures for its delivery. For this to be achieved, political commitment needs to be galvanized, with the creation of enabling intersectoral policy structures and processes for the sustained implementation of comprehensive health promotion policies and actions at a country level.

The International Union for Health Promotion and Education (IUHPE) report, 'Shaping the future of health promotion: priorities for action (29)', set out the policies and system conditions necessary for effective health promotion in the 21st century. The main priorities included: putting healthy public policy into practice; strengthening structures and processes in all sectors; increasing knowledge-based practices; building a competent health promotion workforce; empowering communities. The WHO Nairobi Call to Action (22) also outlined key strategies and commitments to close the implementation gap in health promotion, especially in low-income countries. Among the strategies emphasized were: developing knowledge and skills for intersectoral collaboration, and effective delivery as a means of achieving a critical mass of capacity for health promotion globally. Over a decade later, these goals remain unmet in many countries, and the actions outlined are still required to strengthen health promotion systems and ensure successful implementation. A report on fostering health-promoting health systems in the European Union (30) called for a strengthening of the capacity of countries to implement health promotion at a political, policy and service delivery level and recommended a range of policy measures and financial mechanisms to support the implementation of transformative health promotion policies and practices.

Enablers and requirements for strengthening health promotion

In this section, key enablers and system requirements for comprehensive health promotion initiatives are considered, including those at a conceptual, policy and practice level.

Effective health promotion advocacy

Effective advocacy approaches are needed to promote a better understanding of health promotion and to communicate clearly its key purpose and functions and raise its visibility within public health, the health sector and in society more generally. Public discourse on health is dominated by a focus on illness and hospitals, and it is, therefore, difficult to mobilize a strong demand or base of support among the public, interest groups and opinion leaders in shaping a health promotion agenda. The distinction between promotion and prevention is often blurred, and there is a lack of understanding of where health promotion sits within public health and the wider health system. As health promotion requires a more long-term commitment and vision for embedding change at a wider societal and population level over time, this can make it more difficult to get buy-in and support from politicians and policy makers (31). Organized advocacy methods are needed to effectively frame the health promotion agenda for different policy, practice and public audiences. As outlined in current health

promotion advocacy models (32), key concepts, evidence and strategies need to be translated into accessible and persuasive language that will raise the profile of health promotion, create a demand for action and enable policy and systems change for advancing health promotion. Effective public engagement is also required to generate a better public understanding of the determinants of health and wellbeing and to demand greater accountability for health creation and promotion at a country and government level.

Policy structures and processes

The predominance of a medicalized culture within health systems reinforces a policy focus on illness and health care services and can lead to resistance in addressing more comprehensive approaches required to address the upstream determinants of health (33,34). Even when health promotion is included in health policy, this can result in a drift towards topic-specific and narrower behaviour-change initiatives ('lifestyle drift') with less of a focus on comprehensive intersectoral approaches, which are more complex and more difficult to coordinate and evaluate (24,35). The perceived complexity and broad scope of health promotion can result in a diffusion of responsibility and a lack of institutional ownership. In addition, interference from vested commercial interests can also make securing political and policy support quite challenging (36).

To strengthen health promotion systems, a number of key system requirements have been outlined in a Position Statement by the International Union for Health Promotion and Education (37). This Position Statement calls for leadership at the highest political level and intersectoral governance in adopting robust policies and action plans and ensuring that the necessary institutional capacity, funding and resources are made available for effective and sustained implementation of health promotion actions. Systems requirements are also outlined at the level of creating enabling implementation structures and delivery mechanisms. These include creating the necessary organizational capacity within the health system and beyond, partnership working across sectors, technical expertise and the training and recruitment of a competent and skilled health promotion workforce. Each of these requirements will be addressed in turn.

Political and policy requirements

Political commitment is key to addressing institutional barriers at a policy and political level and bringing a clear focus on the promotion of population health and health equity. While some countries have established dedicated policy divisions for health promotion, few have dedicated ministerial level responsibility specifically for health promotion. Having such a position ensures commitment to health promotion within the political and policy system, and addresses the need for clear responsibility and accountability for delivering on health promotion at a national or regional level.

The development of national action plans with a clear set of health promotion goals and specific objectives are also critical for ensuring that policy objectives are translated into priority actions. Such plans need to clearly specify desired outcomes, processes and mechanisms for delivery and accountability for action over a specified period.

Enabler requirements

Sustainable financing of health promotion is crucial as adequate funding needs to be safeguarded to ensure continuation over time. A study by the Organisation for Economic Co-operation and Development (OECD) (19) shows that less than 3% of total health care expenditure is typically spent on prevention and health promotion, with spending dropping dramatically during periods of economic recession. Protection mechanisms are required, for example, through clearly earmarking funding or setting target levels or percentages of total health expenditure. Institutions such as Health Promotion Foundations have been established to provide new modes of paying for health promotion (38). A number of options for funding multisectoral health promotion actions have also been proposed, including earmarked funding, delegated financing, budgeting schemes and new investment models (39,40). Dedicated and sustainable funding is critical to ensure that health promotion priority actions can be properly resourced and sustained into the future.

Dedicated health promotion institutions with a clear mandate for health promotion policy development, programme implementation and evaluation are needed to strengthen action at national and regional levels. Institutional structures, such as health promotion institutes, foundations,

government departments and service provision arms, need to be established and appropriately resourced at a country level. These structures are vital to effective health promotion implementation and advancing the development of dedicated health promotion practice functions.

Mechanisms for cross-sectoral collaboration are needed to address the determinants of health and implement a HiAP approach. A clear governance structure for health promotion is required to ensure delivery on priority strategies across different sectors and government departments. This involves processes for inter-governmental policy development, including health impact assessments of public policies and cross-sectoral decision-making and planning processes to ensure policy coherence (41).

High-level leadership ensures that health promotion is prioritized within national policies and that technical guidance and resources are provided for the implementation of priority health promotion actions. Health promotion leadership is necessary for the strategic development of organizational structures and processes for planning, implementing, evaluating and sustaining innovative intersectoral actions and strengthening health promotion capacity at a national level.

Health promotion workforce competency is essential to effective implementation and requires a cadre of skilled and trained practitioners with the necessary knowledge and skill-mix (42). International developments led by IUHPE have identified core competencies for health promotion (43,44), including a comprehensive framework for informing workforce development and training in Europe (45) and an international competency-based Accreditation System, which accredits individual health promotion practitioners and postgraduate level educational programmes globally (https://www.iuhpe.org/index.php/en/the-accreditation-system). These competency-based frameworks provide an important quality assurance function for health promotion practice and shape the curricula for postgraduate training and professional development for the next generation of health promoters.

Delivery and implementation requirements

Effective implementation of comprehensive health promotion interventions calls for infrastructures that can support delivery both within the health system and across sectors. This requires the development of organizational capacity and structures with a clear mandate to support delivery of intersectoral health promotion at the national and local level.

Effective partnership working is needed to develop and sustain health promotion actions across sectors, working in collaboration with communities, governmental and non-governmental agencies (46). Effective consultation processes and community engagement strategies are also required to enable active public engagement in policy and practice development (47), including meaningful participation by vulnerable and socially marginalized groups and young people.

Investment in evidence generation and evaluation is necessary to build a strong evidence base for health promotion and ensure that evidence is translated into policy and practice. Research evidence is needed from intervention and implementation evaluation studies, evidence synthesis, economic studies and epidemiological studies of positive indicators of health, to support effective health promotion strategies and inform the scaling-up and sustainability of interventions, especially in low-resource settings. The complexity and breadth of health promotion practice requires a wide spectrum of research methods, including innovative transdisciplinary methods that can capture the systemic impact of upstream and multilevel intervention approaches. Methodologies to undertake the systematic assessment of the health equity impact of policy making across sectors are also needed to support HiAP implementation and monitoring. The development of knowledge translation (KT) for health promotion is especially important to promote the more effective use of evidence in policy and practice. Building on initiatives such as the IUHPE Global Programme on Health Promotion Effectiveness (48), further investment is needed in strengthening KT functions through the development of dedicated health promotion KT programmes. KT mechanisms play a critical role in ensuring that existing knowledge and evidence is translated effectively to address health challenges and that evidence-based tools, methods and services are developed to support best practice and policy and reduce health inequities.

Conclusions

Transforming health systems to achieve health equity, the SDGs and ensuring that we build back

better post-COVID-19 requires considerable change and calls for a re-aligning of health policies and systems with the values, principles and strategies of health promotion. To ensure transformation means investing in comprehensive and innovative health promotion policies, practice and research that will act as drivers of population health, wellbeing, social and economic development and a flourishing and sustainable society. A range of mechanisms outside of the health sector will need to be applied to support the implementation of transformative health promotion policies and practices, including reforms in other policy areas that can address the wider determinants of population health and reduce health inequities. This will require strong political and technical leadership and investment in developing the policy mechanisms and organizational capacity for effective intersectoral action.

Reviewing current progress, it is clear that prioritising health promotion on the policy agenda and integrating it more effectively within health systems requires a strengthening of the essential health promotion functions at a broader political and policy level as advocated by IUHPE (37). There is an urgent need to address the longstanding underinvestment in health promotion and to tackle fragmented and inadequate implementation at a country level. A comprehensive response to the implementation of the SDGs and UHC, and the pandemic, calls for a clear focus on strengthening health promotion systems. This entails advancing the following critical actions: (i) developing effective advocacy to promote a better understanding of health promotion and its key purpose and functions; (ii) enabling policy structures for universal health promotion actions on a cross-sectoral basis; (iii) establishing effective implementation systems, support mechanisms and workforce capacity for multisectoral health promotion action; (iv) developing innovative research and KT methods to inform transformative health promotion approaches. In strengthening the capacity of countries to implement health promotion, sustainable and dedicated funding is required, together with the organizational and workforce capacity to deliver effective health promotion interventions.

As the global professional body for health promotion, IUHPE plays a vital role in advancing transformative health promotion actions. The new five-year strategy (IUHPE 2021–2026) places strengthening health promotion systems at the centre of its priority actions, as this underpinning requirement is critical in addressing global health challenges, supporting action on the determinants of health, mental health and wellbeing and the development of the health promotion field (see details at: https://www.iuhpe.org/index.php/en/). Working in collaboration with international members, partners and agencies, IUHPE emphasizes the importance of advocacy, leadership, capacity development, knowledge development and translation in supporting countries to implement comprehensive health promotion strategies and strengthen the quality of health promotion policy, research and practice. Central to this is IUHPE's role in mobilising and supporting the global community of health promoters in developing and implementing health promotion actions that will deliver improved population health and health equity, transform health systems and enhance human wellbeing and sustainable development. It is time to implement what we know works in promoting health and wellbeing and ensure that the infrastructures and systems are in place to support evidence-informed and sustainable comprehensive health promotion actions globally.

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ORCID iD

Margaret M. Barry https://orcid.org/0000-0002-9464-7176

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Original Article

A health political science for health promotion

Evelyne de Leeuw, Patrick Harris, Jinhee Kim and Aryati Yashadhana

Abstract: If health promotion as a field of change for human and ecological health is to maintain its urgency, it needs to continue building its policy credentials. This paper charts the development of policy as a concern for IUHE/IUHPE (International Union for Health Education/International Union for Health Promotion and Education) from the mid-1970s when 'health education policies' were prominent issues, to the launch of Healthy Public Policy (in the 1980s) and Health in All Policy (in the 2000s). We argue that solid conceptual and theoretical foundations exist to frame and develop the relevance and connectedness of health promotion more prominently. We start off with a brief introduction into (health) political science, and then illustrate the urgency of the argument with three case studies. The first takes a critical realist perspective on 'closing the gap' in Australian Indigenous populations. With recent evidence it demonstrates that the core of the policymaking process needs to re-align itself with an Indigenous narrative. The second case study reviews the politics of healthy urban planning and health equity in cities. Taking a critical theory institutionalist view, the case describes how the political and narrative parallels between urban theory and health equity have gone underexplored. With an explicit gaze to connect the two, the field could become a large and influential driver of enhanced health promotion and public health policy. The third case describes the languages, policy frames, and distinctions, in four urban/health paradigms. It shows that unconscious policy and practice bias exists in policy priorities and processes. We conclude with observations and recommendations on the role of health promotion as a conceptual realm and field of activity. We show that all health promoters should be aware of the political nature of their enterprise. Tools and analyses exist to help further action.

Keywords: Health promotion, healthy cities/healthy communities, policy/politics, politiques/politique, políticas/política, Indigenous health

A potted history from education to promotion, and the emergence of HiAP

Modern health promotion has been embracing the importance of *policy* whole-heartedly. The participants of the conference where the Ottawa Charter for Health Promotion was developed enthusiastically drew on the pronouncements by Trevor Hancock and Nancy Milio that Healthy Public Policy (HPP) must be developed. Both had seen how virtually every dimension of the human endeavour, and indeed planetary dynamics, impact on health (1). A complete bibliographic overview is provided by Harris and Wise (2).

Before this emergent vision in the mid-1980s, the then-International Union for Health Education only had a peripheral interest in policy. Shepherded by Annette Kaplun and Rosmarie Erben, the European branch of the Union had started to publish regular compendia, mapping the field of health education in the European Region of the World Health Organization (3,4). But national and institutional politics were shifting, and the field felt it needed to position itself closer to the epicentre of healthcare

Centre for Health Equity Research, Training and Evaluation CHETRE, University of New South Wales, South Western Sydney Local Health District, and Ingham Institute for Applied Medical Research, Liverpool, NSW, Australia

Correspondence to: Evelyne de Leeuw, CHETRE, University of New South Wales, Locked Bag 7103, Liverpool, NSW 1871, Australia. Email: e.deleeuw@unsw.edu.au

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policy. The fourth (and last) edition of this 'Health Education in Europe' was edited by Wieberdink (5) and was almost instantly redundant and superfluous.

The embrace of the notion of policy, however, did not necessarily mean that great scholarly or practical insight in the machinery and politics of the policy process was deployed. As an aspirational movement, 'Ottawa Charter' type health promotion still brought a history (and burden) of mechanistic health behaviour change perspectives, in which 'policy' was all too often seen as an impenetrable black box – a misapprehension that remains to this day – or one that is best left to insidious politicians and their bureaucrats.

Very few systematic or political science driven (or even motivated) inquiries into HPP making were undertaken in those early post-Ottawa years (6,7). This changed somewhat when global networks of healthy settings, and most notably Healthy Cities, started to take off in earnest. The promise of whole-of-government (WOG) policy (also known as joined-up-government (JUG)) for health continued in jurisdictions globally in Healthy Cities or Health Action Zones (in Britain (8)), at the regional level (North Karelia (9)), or in organisations (such as the higher education sector (10)) – the need for an informed analysis of policy process for health did not go away.

The ideas of WOG and JUG emerged almost simultaneously in a different guise in South Australia and Finland, and through policy entrepreneurship soon arrived in the offices of the World Health Organization (11). The new 'magic' term was 'Health in All Policies (HiAP)' – more a process approach than an output focused idea for policymaking. Collections of literally hundreds of case studies have been compiled showing how this health care sector agency should be deployed (12), how it should be assessed (13), and to what desired effect (14). Regrettably though, of the several thousands of health promotion policy research papers published in the first decades after the Ottawa Charter, only a handful systematically applied theories and concepts from the broad scholarly domain of political science (15). Instead, policy and political processes are viewed through a lens of behaviourist theory at best, or through unsystematic case descriptions at worst.

The approach to building HiAP (and/or HPP) remains largely atheoretical (15), both in terms of analysing the policy process as well as in evaluating the process and its outcomes. Health promotion research in, for, with, and on policy and politics remains as agnostic as the field of public health in general (16). And yet, in its rhetoric the health promotion field is expressly, and politically, pursuing systems and policy change.

Health political science

The foundations, evolution, and different branches of what can broadly be called 'political science' are a rich field of tradition and research. For many, it includes administrative sciences and the study of international relations. Naturally, there are overlaps and contestations with other social sciences, such as (network) sociology, science and technology studies, decolonising or feminist perspectives, and others. Understandably, for any health promotion scholar or practitioner to navigate this ecosystem can be daunting. For instance, even the concept of 'policy', more than 85 years after Laswell (17) defined it as 'Who gets what, when, why and how?', is still fraught. But a core understanding of policy and politics as playing out in processes of power and contestation over values and priorities should be a useful start. Such a view ought to resonate well with the activist foundations of health promotion (18).

The contestation starts with core concepts. What, for instance, is 'policy'? Sometimes it is considered merely equivalent to 'the plan' ('This is how we will get from A to B') or a rule ('No access to people under three feet'). For instance, in Australia, the vast inequities experienced by Indigenous peoples (in health, housing, liveability, education, etc.) were finally elevated to 'policy' level. Arrangements are put in place (a National Indigenous Health Equality Council (2008) based on a National Indigenous Reform Agreement) that supposedly set priorities and targets (19). However, none of these seem very effective or are even implemented (20). In our first case study, we suggest why.

Scholars, politicians, and bureaucrats can refer to any of the elements of this approach as a, or the, policy. There is a brief review of perspectives on 'policy (21)'. Noteworthy is the valuable nihilism that 'no policy is also policy' and 'symbolic policy' that is demonstrably ineffective, or only aims to appease certain groups of stakeholders. Ultimately, though, we land on a definition of policy as '... the

expressed intent of government to allocate resources and capacities to resolve an expressly identified issue within a certain timeframe' (15). This lens considers that public (government) policy concerns itself with social issues and the (re)distribution of resources (which include both tangible – money, infrastructure – but also intangible – ideas, access – dimensions). In gross terms, policies (or policy instruments) then embark on three paths of instrumentation: communication (or 'sermons'), facilities and incentives ('carrots'), and coercion ('sticks'). Public policy implementation tends to follow the 'path of least coercion' – that is, politicians prefer sermons first, then carrots, and finally the sticks (cf. Bemelmans-Videc *et al*. (22)). In practical health promotion terms (e.g. in COVID-19 control) this translates into public sector's first preference for media campaigns (distance yourself!), then the establishment of facilities (e.g. plastic shields in shops, markers on floors to encourage physical distancing), and finally – and begrudgingly – regulatory action that enforces lockdowns, fines, etc.

The heuristic for the application of strong theory to health (promotion) policy challenges is beginning to be framed (17,23). Over recent decades a number of 'firm' theories and policy conceptualisations have emerged (24). The identification of a 'proper' theoretical framework very much depends on the context in which the phenomenon under study is cast, and could encompass a (new) institutionalist or critical realist perspective to unpack the dimensions of policy systems of focus and their various mechanisms and influences (25).

It is also important, at this stage, to consider the difference between a political science approach that studies health care (i.e. the distribution and allocation of resources for elements of the healthcare delivery system) and a health political science that studies the (re)distribution of resources for health – the argument that the advocates of HPP and HiAP make. We, therefore, propose as a definition of 'health political science': *the systematic and concept-driven field of study and development that encompasses actors, ideas, processes, and structures aimed at maintaining and/or resolving contested beliefs and priorities in allocating resources and capabilities for improving human and ecosystem health and well-being*.

In the following three brief case studies we show examples of such a health political science approach. They cover three areas of interest where the policy (and political) dimensions of health promotion are perhaps more pregnant than in behavioural intervention programmes. First, we look at Indigenous health policy. Then, we shine a light on urban planning as a health promotion endeavour. And finally, we show how ontologies ('how the world works') of a particular domain shape the policy directions – in this case, of the broad field of health and the human-shaped environment (more often called 'urban health', but this is a particular paradigmatic flavour, as the case study demonstrates). There are many other health promotion arenas where policy and politics are blatant – they include commercial determinants of health, planetary and ecological health, and many of the current challenges to emerge from the COVID-19 pandemic. Too many to address in this piece, and fertile lands for future health political science reflection.

Understanding and framing Indigenous health: the gap

Much of the policy discussion around, and subsequent funding of Indigenous health in Australia is focused on 'the gap' between Indigenous and non-Indigenous health outcomes. The concept of the gap assumes that when Indigenous health indicators match those of their non-Indigenous counterparts, 'equity' has been achieved. An example is the gap in life expectancy, where Indigenous Australians die, on average, between 10 and 15 years earlier than their non-Indigenous counterparts (26). Policy and funding allocation under the 'closing the gap' (CTG) banner began in 2008, and primarily through supporting Aboriginal Community Controlled Health Services (ACCHSs), has achieved some progress against defined health indicators (27). However, there has also been much stagnation, or against some indicators a widening of the gap (27).

Using health political science to frame the gap, and the CTG policy environment, provides a way to understand its underlying discourse, including why progress has stagnated. Discourse analysis is key in applied health political science, as it observes the interplay between ideas and health policy actors and attempts to identify where and how interests, beliefs, and knowledges become dominant (28). The dominant discourse surrounding the gap, and the way in which knowledge is produced to legitimise it,

is part of the problem. For example, epidemiology remains the dominant methodology used to describe the gap, focusing on indicators of ill health or perceived behaviour deficits (27). This aligns with the tendency to apply quantification to complex issues of health inequity (29). Scholars applying a socio-political lens to CTG policy have argued that the dominance of, and reliance on, epidemiological measures of the gap, have limited its closure by disregarding race and racial difference as its key mechanism (30). Rather than acknowledging its structuring effects, race is reproduced uncritically and continuously against targets that serve neoliberal (e.g. free market capitalism, deregulation, radical individualism) political agendas and 'Western' biomedical values (27,30). A previous analysis of the CTG policy environment (27) suggests these approaches are perpetuated by institutional norms, short electoral cycles, and a lack of Indigenous representation in policymaking.

Framing Western biomedical neoliberalism as a core belief (31) evident in the politics and the policy discourse of the gap, points to an intersection where ideas are transformed into institutional power. The resourcing of ACCHSs provides another example; where despite being a crucial contributor to improved Indigenous health and well-being, the government funding that keeps them afloat is short-term (1–3 years). It is driven by financial efficiency, performance indicators, and bipartisan politics, rather than cultural safety, sustainability, and longevity (32).

Another angle of analysis is Indigenous cultural sovereignty, and its interface with governance and policy structures. The maintenance of Indigenous language and cultural practices have been evidenced to support well-being, and serve as a protective element from racial discrimination (33) and its harmful health effects (34). Yet at the interface with health systems and policies that reinforce hegemonic values and interests, Indigenous cultures serve as a 'barrier', reinforcing a socio-political history where Indigenous peoples have always been othered as a problem (35). This reflects an underlying form of discursive power that seeks to normalise Western neoliberalism, and its pursuit of 'civilisation' via a linear process of modernity, as superior (to Indigenous cultures) (27) – a process of assimilation. A recent theoretical analysis of Indigenous eye health inequity (36) suggests that the mechanisms underpinning poor clinical outcomes, at their core reflect a tension between the core beliefs of the health system and its actors (that of Western biomedical neoliberalism) and Indigenous patients who strive to maintain cultural sovereignty. A subsequent case for policy reform has been made to increase resourcing of 'non-clinical' roles (e.g. Indigenous interpreters, cultural brokers), that support Indigenous patients during their interactions with hegemonic norms and values within health and policy systems (37).

Using health political science to understand framing is key, as it tends to reflect or respond to political institutions and the power of decision makers to influence the content of health policy or policy strategies (28) such as CTG. Critical discourse analysis of the gap and its associated policies, have called into question its cultural trajectory, hypothesising whether a merging of the lines reflecting Indigenous and non-Indigenous health outcomes demands a kind of assimilative process (38). A relentless restriction of Indigenous sovereignty and power, renders a closing of 'the gap' (in all facets of society) politically challenging. The social complexities reflected in the gap, reinforce the importance of applied health political science, to better understand how dominant political value systems create and reproduce inequitable health outcomes among Indigenous peoples.

The politics of healthy urban planning

Most of us live in cities. Even more of us are 'urbanised' in one way or another. There is a long line of knowledge and evidence linking cities and urban places and spaces with our health and well-being (39). From a health political science perspective, urban planning and policymaking systems are a wonderful crucible with which to unpack politics and policy (25). Indeed, there has been a great deal of crossover between political scientists and urban political scholarship. Sadly, however, much research into health and urban planning remains 'a-theoretical' and not engaged in health political science (e.g. Pineo *et al*. (40)).

Here, we outline some of the various dimensions of urban politics that health promotion practitioners ought to look out for. The first concerns the policy cycle and sub-systems (41). Urban planning systems are a good example of how the policy cycle is an

heuristic rather than reality. Urban planning policy systems tend to be layered, with different sectors (e.g. transport, housing, local government, education, parks, and public amenity maintenance) beholden to their own rules, stages, and timings. Plans and projects are delivered at local levels and are subject to meeting the requirements of a range of further regulatory and policy processes. Crucially, projects or activities flagged for implementation often require the private sector to build them and should involve the public. Overall, each layer of the system provides an important opportunity for collaboration and potential to influence . But the timeframes are long (31) and there is no clear cycle to how urban (health) policies are developed, implemented, evaluated, and reviewed. The best advice is to keep paying attention to whichever level of the system one is interested in influencing. Second, urban policy systems are best viewed with an institutional lens (41). Institutions, political science shows, are made up of various essential dimensions: structures, actors, ideas, and processes (25,42). In turn, these dimension are subject to dynamics: power, governance, and time.

Structures are the rules and mandates that influence policymaking. They embody the power of the system, and are necessary to understand if change is sought and the system challenged. Urban politics are structured by the political economy of globalisation and neoliberalism under the banner of what has come to be known as 'urban competition (43)'. Urban competition essentially covers the positioning of 'city regions' whereby cities' functionality for creativity, innovation, development, and competition positions them within a globalised economy (42,44). At the most 'macro' structural level, the city-region approach came about in the wake of the transition during the 1970s and 1980s to the loosening of regulation to emphasise market rationality in urban policymaking (45). Within cities, several mechanisms enable them to be the globalised 'centres of economic production and exchange (44)'. One – agglomeration – is a policy goal that concerns the spatial clustering of divisions of labour, sharing urban services as public goods, matching people and jobs, and stimulating innovation through formal and informal information flows (44). Another – urban managerialism – reflects Keynesian economics being overtaken by 'new urban entrepreneurialism' in response to the declining powers of states to control the out-flow of capital to multinationals, 'to maximise the attractiveness of the local site [the city region] as a lure for capitalist development (46)'. Ideas, or the content of policy, clearly overlap with structures but they also provide opportunities to challenge and change politics and policies. For example, many of the core ideas within the 'urban competition' thesis can be challenged from a social or health equity position. For example, entrepreneurial approaches to urban policy where partnerships with private finance are a core task of government representatives come with in-built inequity: 'winners being sharply divided from losers' and an ambiguous state autonomy from private interests (43, p.494). From a health promotion perspective that champions health equity as a core idea, this seemingly sophisticated unpacking of cities as centres of global competition is problematic. Unwavering support of city region competition driven by market mechanisms is ultimately, and fundamentally, challenged by a social equity critique. The preference for the Competitive City over and above other normative approaches to what urban politics could be – for instance, the Just City – is questionable when the result is greater social inequalities (43).

Third, actors, or those involved in policy or influencing policy, are also crucial. Most modern-day urban political analysis focusses on the roles and positions of the many different actors involved. These dynamics are usually understood by focussing on governance. The urban competition approach tends to bring about governance that is private sector focussed, and emphasises investment and financing of city regions, mostly through large and expensive infrastructure projects. These regimes tend to exclude actors with a social equity goal, or even local communities who may have particular concerns about the local place where they live. Perhaps unsurprisingly, the top-down, competitive city approach to urban governance has been subject to sustained critique whereby localised, bottom-up strategies are also necessary – especially where social justice and equity are concerned. Urban governance aimed at shoring up global competition may also shore up existing uneven power relations rather that delivering on promises of greater democracy and grass roots empowerment (47). Concerning urban infrastructure investment, for example, the urban Geographer David Harvey's early analysis cautioned that while infrastructure investments can benefit

whole regions they tend instead to favour local 'coalitions of property developers and financiers (46)'.

We conclude with a finding that brings structures, actors, and ideas together. The ultimate health-political-science-informed governance challenge facing health-promoting cities' regions and places is balance in the face of a great number of often competing interests. Healthy urban planning can be best perceived as a continued search for balance across different political interests: between fostering private investment integrating the business community into collectively defined locally impactful activities that benefit health and health equity, and all the while asserting just enough regulatory or policy control that business does not relocate because of regulatory constraints (48).

There is no doubt that working towards health in all policies/HPP is intersectoral, interdisciplinary, and political. The enduring problem of urban health inequity requires health promotion professionals to think in novel and impactful ways. We will only be able to think in this way if we accept and integrate knowledge and ideas from other sectors and disciplines into our health political science discipline.

Questioning spatial health policy ontologies

A health political science perspective to understanding the complexities of urban health policies starts from identifying the actors and their paradigmatic positions. Urban health is a field of research and action that requires intersectoral action and multidisciplinary approaches. However, different professions and sectors view urban health issues based on their conceptual, theoretical, methodological, instrumental, and even historically determined perspectives. These views, or paradigms, are reflected not only in the vocabulary and definitions they use, but, more importantly, they inform which policy problems are worth addressing and their appropriate and preferred solutions.

In the field of urban planning and health, there appear to be four distinctive paradigms – the 'medical-industrial city' (MIC), 'urban health science' (UHS), 'healthy built environments' (HBE), and 'health social movements' (HSM) (has an earlier typology) (49). Each one of these is characteristically unique in their views on:

- which urban health issues are more important (a *conceptual* gaze);
- what causes these urban health issues (*theoretical* frameworks);
- which data collection or analytical method would best measure and seek information (*methodologies*); and
- which solutions effectively resolve the prioritised issues (*instrumental dimensions*).

The MIC paradigm is driven by the business and industry sectors and the government (50). Policy participants who adhere to this paradigm believe that investing in healthcare infrastructure and health-related technologies will stimulate urban economic growth. The idea of health is coupled with liveability or healthy lifestyles that support economic prosperity. This paradigm is prominent in initiatives such as the large-scale healthcare industry and infrastructure-centred urban development projects or smart city (for health) initiatives.

Proponents of the UHS paradigm apply epidemiological and classic Cartesian analytical methods to empirically examine the complex causal relationships between the urban environment and its health impacts (51). These types of evidence are critical in designing and evaluating effective interventions and policies. Actions following this paradigm are generally technocratic and propose lists of proven policies or best buys.

The HBE paradigm has an explicit focus on transforming the sets of procedures, institutions, and regulations that constitute the urban and spatial planning system (52,53). Researchers and policy actors following this paradigm suggest codes or guidelines to be applied to review development proposals to ensure health. Healthy urban development checklists and healthy urban planning guidelines are examples following this paradigm.

Finally, the HSM paradigm emphases values such as health equity and empowerment in the identification of urban health issues (54,55). The solutions are ideally driven by the empowered community, focusing both within (in community-driven action) and outward (in mobilising for policy and systems change), as is represented well in the WHO Healthy Cities movement.

Initiatives that aim to promote health through healthy urban planning appear in all four paradigms but can be broadly recognised through

the policy goals and policy instruments and settings that each propose. For example, the overall policy goal of promoting health is conceived as neoliberal economic prosperity (MIC), morbidity and risk factors (UHS and HBE), or health equity (HSM). Beliefs on effective policy instruments to achieve the goals range from building of large-scale infrastructure to boost economic growth (MIC), describing the urban health problem (UHS), transforming the spatial planning system (HBE) and community-driven solutions through empowerment (HSM).

Using the urban health paradigms as a framework to identify co-existing paradigms is one strategy health promotion practitioners can adopt to seek strategies for policy change and transdisciplinary collaboration across the different methodological and instrumental beliefs. The role of ideas and beliefs (in other words, 'ontologies') is central in the policy process. For example, policy actors 'institutionalise' their shared ideas and beliefs into the rules and norms of the decision-making structure or coordinate their actions to influence policy change. Standard policymaking, or incremental policy changes, occur in lower-level belief systems on policy instruments and their settings, while maintaining the overall policy goal occurs within an existing paradigm (56). In the case of a stable system, where one paradigm remains in control, a major policy shift is unlikely to occur without a significant policy failure that produces a shift of power within the government (56). And because specific ideas on their own do not have the power to influence change, they need to be framed within the conceptual understandings of others to gain support.

Conclusion

There is a rich and diverse tapestry of theories and understandings of the policy process (57). The conceptual and disciplinary gazes that we deployed in the above case studies are not necessarily part of the mainstream of health promotion research. Our intent was to show the added value of health political science theorising to health promotion.

This may appear a rather esoteric exercise within the broader remit and understanding of the health promotion enterprise. However, in order to advance our effort, and the actual '... process of enabling ... control over the determinants of health' (59), the survival of the field depends on embracing this type of understanding and integrating it into every dimension of the endeavour. This requires transparency and advocacy for our policy ideas and concepts, and how we approach the resulting variables with particular methodologies. The momentum seems to be shifting and increasing numbers of rigorous studies are undertaken. They will lead to deeper insights into the health promotion policy process, and in particular into the roles we can play in the dynamic networks they comprise.

This does not mean we argue that all (practical, scholarly, and policy sector) health promoters must become health political scientists. Yet, our definitions of health policy and health political science indicate that processes of contestation and power over ideological and resource directions are essential. Any health promoter should recognise these core mechanisms to our 'business'. Health political science views may help.

This means that a more profound recognition of the political nature of the field, and the fact that there is a substantive conceptual body of knowledge and practice behind this, must become part of everyday practice. Rudolph Virchow is often quoted to frame this political nature.

> Medicine is a social science and politics is nothing else but medicine on a large scale. Medicine as a social science, as the science of human beings, has the obligation to point out problems and to attempt their theoretical solution; the politician, the practical anthropologist, must find the means for their actual solution. (58)

But rhetoric is just words. What we need is action, and firm conceptual grounding. We have provided the foundations for this.

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ORCID iDs

Evelyne de Leeuw https://orcid.org/0000-0003-3434-1439
Aryati Yashadhana https://orcid.org/0000-0003-2573-8637

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Health promotion research has come of age! Structuring the field based on the practices of health promotion researchers

Louise Potvin[1] and Didier Jourdan[2]

Abstract: Health promotion is mostly framed as a discourse and practices based on a set of values and principles that promote changes at various levels (individual, community and global). There is no well-defined knowledge base and no widely agreed knowledge development methods. During the past decades, health promotion knowledge has developed following a potluck model. Researchers from various disciplinary backgrounds attracted to the values and transformative vision of health promotion have used their disciplinary-based research methods and theories to conduct studies about the various practices that are associated with health promotion. Although health promotion research has acquired many attributes of a distinct field, researching practices from various disciplinary perspectives is not sufficient to create a coherent knowledge base for health promotion. We propose three dimensions to further structure health promotion research. The first relates to the object for which knowledge is produced. For health promotion research this relates to health social practices. The second dimension relates to the purpose and ethics of research. In the case of health promotion research it pursues the dual purpose of producing knowledge (epistemic aim) and contributing to social changes (transformative aim). The third dimension concerns the knowledge produced and the conditions for valid knowledge. In the case of health promotion research, the condition of knowledge production should include a recognition of the complexity of social practice and the necessary dialogue between scientific. True to health promotion principles, we propose a bottom-up process for structuring the field through the creation of a 'Global Handbook of Health Promotion Research' that would draw on the research practices of those involved in health promotion research.

Keywords: Health promotion, research, practice

Introduction

Apart from the Bangkok Charter that calls to anchor health promotion practice on the best available evidence (1), there is not any mention of research and of relevant scientific knowledge in health promotion founding documents. Health promotion is mostly framed as a discourse and a professional practice based on a set of values and principles that promote changes at the individual, community and global levels (2).There is no well-defined knowledge base and no distinctive, widely agreed knowledge production approach for health promotion research. Nevertheless, during the past decades, health promotion knowledge has developed and gained recognition as witnessed through various signs of scientific institutionalization (scientific journals, graduate research-oriented programs, departments in higher education institutions and research units in universities) (3).

Like other applied fields, health promotion research developed following what we would call a potluck model. Researchers from various disciplinary backgrounds, attracted to the values and

1. Université de Montréal, Montreal, Quebec, Canada.
2. Université Clermont Auvergne, Clermont-Ferrand, Auvergne-Rhône-Alpes, France.

Correspondence to: Louise Potvin, Université de Montréal, CP 6128 Succursale Centre-ville, Montreal, Quebec, H3C 3J7, Canada. Email: Louise.Potvin@Umontreal.ca

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transformative vision of health promotion, have used their disciplinary-based theories and methods to study health promotion practices (4,5). A recent bibliometric analysis of material published in reference journals for health promotion research shows the breadth of conceptual and methodological sources used in the field (6). The question arises as to whether health promotion research is still at the potluck stage or is it now a constituted, distinctive field of research. In other words, is health promotion research simply a crossroads where researchers from different disciplines temporarily meet or is it a field of research on its own with its objectives, epistemological frameworks, methods and specialists? This question concerns all research fields founded on social practices (see, for example, Wyse *et al.* (7), on education science) in contrast to those founded on a specific approach to reality (physics, sociology, and so on). Based on existing mapping of the field, we suggest that health promotion research is a distinct field of research in need of an explicit and shared framework to structure and unify its knowledge base. In this paper, we discuss three structuring pillars that build on existing health promotion research practices and propose a direction to jump-start the structuring process.

A distinct field for health promotion research

After 35 years, health promotion has become an umbrella concept for a diversity of programs and policies addressing the non-medical determinants of health. Recognizing that the development and implementation of such interventions require system and organizational capacity, some countries have institutionalized health promotion (8). Common to these institutions is a clear orientation towards intersectoral action and efforts to engage in the process, and a broad range of societal actors, reaching well beyond the medical sector. Originating in a WHO-EURO effort to operationalize the goal of 'achieving health for all in 2000 (9)', health promotion has become global with the recognition that noncommunicable diseases and modifiable lifestyle risk factors had become major causes of disease and mortality, even in low- and middle-income countries (10). Although health promotion also happens under the auspice of civil society, its sustainability as a professional activity and institutionalization in public administration requires a valid, distinctive knowledge base to buttress other elements of professional sustainability such as training programs, accreditation processes and competency frameworks (11).

Parallel to these geographical and institutional expansions, health promotion has also penetrated the academic domain. The fact that a growing number of scientific journals, research infrastructure and specialized academic degrees include health promotion in their title is a sure sign of a thriving scientific enterprise. While research teams are capable of producing scientific knowledge, the field of health promotion research is yet to be recognized as distinct and associated with a consistent body knowledge anchored in shared paradigms, approaches and methods (12). In comparison to theory-based fields of research such as psychology, sociology or epidemiology for example, health promotion research could appear to be weak from an epistemological point of view. It is ill-defined, with blurred boundaries and fluid concepts. It is still in search of a proper niche as witnessed by the fact that these research infrastructures and degrees are associated with various scientific disciplines that range from psychology, education, and social work, to various allied health sciences such as public health, nutrition and others, depending on university traditions (8).

The key questions are then, what are the criteria to define a research field and does health promotion research meet these criteria. A field of research is a structured space of relationships for social actors, both individual and institutional (in our case, people involved in health promotion research). It is defined by its boundaries with other related fields (such as public health or political science), and it defines an identity for those within. Actors in the field struggle to obtain significant shares of various types of capital from which they can position themselves favourably within this space (mainly peer recognition, role in scientific journals in the field or organizations) (13).

As the hallmark of health promotion research, the plurality of disciplinary perspectives has also led to a multiplicity of subjects and concepts for which health promotion research claims to be in a position to produce valid knowledge. This diversity of concepts was shown by a recent bibliometric analysis of major scientific publication venues often

cited in health promotion research (6). Health promotion research has developed through the entrepreneurship of various individuals who use their disciplinary background and methods to study phenomena and concepts that they relate to the transformative vision of health promotion as outlined in the Ottawa Charter (14). The field of health promotion research could appear as a disparate set of subjects for which there seems to be no real ordering principle other than the attraction of the Ottawa Charter, and in which all methods seem to be acceptable to the extent that they are rooted in a disciplinary perspective (15). Researching a range of practices from various disciplinary perspectives is not sufficient to create a coherent knowledge base for health promotion as illustrated by the debates about what constitutes valid evidence for health promotion that has burgeoned for the past 20 years (16,17).

We suggest that health promotion research has many of the attributes of a distinct research field. What is missing is a recognized structuring framework that will facilitate the development of the other attributes such as a clear identity of health promotion researchers and scholarly associations. Developing such a framework for health promotion research is the next step in this field-formation process.

Three structuring dimensions for the field of health promotion research

Research is an intellectual activity aimed at producing new and cumulative knowledge using scientifically recognized methods within a social and political context. It introduces intelligibility and rationality into complex practical-ethical discussions such as those that characterize the field of health promotion (18).

Research has shown that science is a social activity. The validity of any scientific claim is rooted in the worldviews, methods and tools elaborated by those recognized as contributing to the discipline in which the claim is embedded (19). It does not mean that there is a need for a consensus about the relevant tools and methods for developing facts and knowledge about health promotion, but there is a need for an explicit framework that defines what health promotion research is. In fact, beyond the positivist myth of research based on solid knowledge defined once and for all and produced thanks to methodological reduction that allows for the study of only one parameter at a time and to generate results that are always reproducible in controlled conditions, research takes different forms. Every research is a singular, original activity that can be characterized by a configuration of attributes pertaining to a limited number of dimensions. What defines the field of health promotion research is a set of specific configurations that could be described according to three dimensions:

- The objects of research.
- The purpose (and ethical framework) of the research.
- The nature of the knowledge generated.

Although important to the identity of a research field, we do not include methods as a structuring dimension. Valid methodological research options are contingent upon already existing valid knowledge and are largely derived from these three structuring dimensions. The configurations of objects, purpose and knowledge base/production specific to health promotion research constitute the pillars on which to anchor the field.

The objects of health promotion research

Logically, health promotion research is about health promotion! In an effort to determine a set of core concepts to define health promotion 20 years ago, Rootman *et al.* (20) identified up to 11 different definitions that roughly cover two decades around the time the Ottawa Charter was elaborated (from 1974 to 1992). The number of definitions is still growing (21). They found some commonalities in all these definitions. They all propose a positive orientation for health and are all action oriented, suggesting five strategies of action involving a large scale of primary actors, from individuals to organizations, from the community up to the state and global actors. These actions address a broad range of determinants of health rooted in everyday life going well beyond individual risk factors (22). Finally, all definitions propose a set of principles to orient those actions. While empowerment and participation are often cited as standing at the core of the health promotion transformative project, the

Ottawa Charter explicitly listed empowerment, participation, equity, holism, adaptation to local conditions, sustainability and intersectoral action as health-promoting values (23).

In the case of health promotion research, we argue that the knowledge produced is about the social practices of health. It is our understanding that during the past 30 years since the Ottawa Charter, health promotion practices can be grouped into four categories, which constitute four distinct 'doings' (12). We propose that those practices constitute health promotion and identify research objects that are relevant for the advancement of the field and that have, indeed, been investigated by researchers in the field.

- *The practices of individuals and populations to maintain or increase their health*. Individual and group practices that are linked to the determinants of health. These practices are anchored in different cultures, knowledge and social contexts. By emphasizing that health is created in everyday life through control over its determinants, health promotion focusses on what people do to produce health. Research related to these practices generally seeks to answer two types of questions. The first type is related to how positive health can be defined and operationalized, so that makes it distinct from the absence of disease. This category of research includes the rich theoretical and empirical research tradition related to salutogenesis (24), those studies attempting to define and measure health literacy, well-being or even happiness at the individual level. The second type of question is related to identifying health determinants, their interactions and the mechanisms by which they are related to health at the individual and at the population level. The study of the interaction between social contexts, cultures and people's health is at the very core of the research on these practices.
- *The practices of professionals and stakeholders to improve population health*. A wide range of professionals from different sectors intervene in health promotion/health education/prevention to improve the health of a group of people and to transform the determinants of health. These health promotion practitioners also include activists, associations, forums and communities engaged in social change for improving health. Over and above evaluation that aims at informing decision-makers and practitioners about the values of specific interventions, health promotion research related to these practices seeks to answer the following question: how do we change the conditions and determinants of health? This formulation suggests the possibility of a science of health promotion intervention, the possibility to develop a cumulative body of knowledge about health promotion interventions that would build on regularities and patterns observable across a number of interventions. Research about these professional practices and the programs created through these practices constitute an important part of the published health promotion literature. In addition to reporting on program outcomes, unpacking the black box of interventions is now considered a requirement for quality health promotion evaluation (25). There is a need to address the practices within health promotion interventions and to document how the principles and values of health promotion are implemented and whether they can be linked to observable transformations in the determinants of health and in health.
- *The practices of policy makers and institutions*. These refer to the implementation and advocacy of public health policies at the national, regional and local levels; not only in the health sector, but also in all sectors that influence the determinants of health. Even if health is created in everyday life, the quality and quantity of resources that are accessible in one's local environment are shaped by decisions that are made at all levels of governance and that concern the redistribution of resources and power: the political determinants of health. In addition, recognizing that most resources that affect health are not controlled by the health sector, partnerships and intersectoral alliances that constitute health governance are of primary importance for health promotion. Research about such practices is concerned by both how decisions are made and how they can be influenced through advocacy and by the impact of those policies on health and its determinants. The former overlaps with political science and there is a growing body of research

that uses political science theory and methods to develop knowledge about health policy process (26). Concerning the latter, the field of health impact assessment that consists of determining the impact of policies developed within or outside of the health sector on population health and its determinants, is also witnessing an important growth.

- *The practices of innovators*. These refer to the network of academic scholars and agencies through which a continued investment in health promotion research and the production of evidence-based practice guidelines are made. This suggests that research is constitutive of health promotion. Knowledge about the practices of those who produce and disseminate scientific knowledge about the three types of practices defined above is essential for the development and implementation of those practices. The mechanisms influencing these practices must be elucidated, as well as the ways in which methods used to produce and translate this knowledge into practice and guidelines align with the values, principles and transformative agenda of health promotion. For example, if we believe that health promotion interventions must be context-specific and should rest on the participation of the parties concerned, then the dissemination of evidence-based interventions has to acknowledge and account for adaptations that will increase the fit with local needs and conditions. There is an emerging literature about how research in health promotion can better serve the improvement of health-promoting practices and, thus, become health promoting itself (27).

Taken together, these four areas of practices delineate the field of health promotion and constitute the objects for health promotion research. These areas are not mutually exclusive, and they overlap with other objects of enquiry in other research fields. However, they are all related to the health promotion transformative project.

Putting social practice at the core of health promotion research requires defining what is meant by practice. In the context of evaluation research, which he argues is concerned with practice, Schwandt (28) defines social practice:

> 'not as an object or thing-like entity or system but as an event (or a series of many events) that is always developing, unfolding and being accomplished. Hence, we are concerned primarily with activities and relationships, with the manners in which people change and develop, and the ways they continually interact with others.' (29, p.100)

Practice is also a form of embodied knowledge. Consciously or not, practitioners (those who are performing practices) are enacting knowledge, constantly adapting knowledge to the context and to those at the receiving end of practices. Thus, researching health promotion is developing knowledge about social practices (29).

The purpose of health promotion research

Health promotion research is defined by a double purpose: producing knowledge (epistemic aim) and contribution to social change (transformative aim) within a well-defined ethical framework (13). Health promotion is action-oriented. Its foundational documents define health as a goal and what needs to be transformed in order to achieve it, as well as a series of means by which these transformations are achievable, the five areas of action cited in the Ottawa Charter. These features of health promotion clearly situate health promotion in the realm of social practices, understood as the transformative actions of actors in the pursuit of valued objectives (29). This is in line with Woodall *et al*. who suggest that one of the four distinctive features of health promotion research is its application to real-world contexts, and 'the development of practice and on appropriate strategies for action on health' (30, p.119).

Because health promotion is principle-driven (20), health promotion research must incorporate an ethical structuring dimension related to its transformative purpose (29). Although a full discussion of an ethical framework for health promotion research is still to happen, there are some identifiable landmarks to open such a discussion.

At the core of health promotion is a commitment to a set of values related to equity, social justice, empowerment and to health as a human right. These values emphasize that the process through which health is created and promoted contributes to the health

outcome (2). Simply put, when prevention interventions lead to increasing health inequalities, it goes against the values of health promotion even if it is effective among some groups (31). There is an increasing concern among researchers about the underlying values of health promotion research and how the process of creating health promotion knowledge should contribute, or at least not impede, health promotion (29,30). MacDonald and Mullet (32) provide a detailed analysis of the tensions that may arise when health promotion programs are studied using research methods that are not fully aligned with principles of empowerment and participation. The damage to health promotion programs evaluated with disempowering and non-participatory research methods might be greater than the consequences on research results of using less robust methods.

Participation and empowerment are two valued principles of health promotion often put forward when it comes to the ethical dimensions of health promotion research. Both have been advocated as strategies of choice in interventions to reduce health inequality (31). Doing 'research on' the application of these two principles leads to a posture in which researchers carry on 'research with'. There are probably other values that could inform an ethical framework for health promotion research and that would be identified through a thorough analysis of health promotion research practices.

The knowledge generated by health promotion research

A third structuring dimension for health promotion research relates to the knowledge it produces and the conditions that make this knowledge possible. This is generally known as epistemology. The epistemological dimension of research refers to the relationship that needs to be established between a knowing subject, and what is to be known, for knowledge to be possible, and hereto the conditions for creating valid knowledge (33). As a multidisciplinary field, health promotion researchers come from a broad range of epistemological horizons, creating epistemological tensions. It is mainly through the ongoing debate about the kind of evidence that can be produced, and what counts as evidence for health promotion that the need to clarify the epistemological dimension of health promotion research has emerged (34).

Because of its close association with public health, the practice of health promotion research has been heavily influenced by epidemiology and the biomedical research tradition. Epidemiology and biomedical sciences focus on establishing experimental causality. They are founded on a positivist epistemology that assumes that health phenomenon are facts of nature, and that the researcher is a neutral outside observer. Establishing causality follows the rules of experimentation, in which a single cause can be isolated and manipulated by the experimenter when holding constant, or controlling for, all other potential causes. Whenever true experimentation is not possible, epidemiology has established a series of methods and criteria to make possible the inference that an effect can be attributed causally to a given factor or series of factors. This, in turn, has led to a hierarchy of scientific evidence on top of which sits the randomized controlled trial that serves as a golden standard to gauge the validity of all others.

Applying such an epistemology to study the social practices of health promotion has highlighted numerous limitations of the positivist epistemology underlying biomedicine and epidemiology (35). Many of these limitations have been discussed extensively in the health promotion literature. Within the scope of this paper, we emphasize two positivist assumptions incompatible with conceiving health promotion as social practices. The first relates to causality and the possibility of isolating causes without affecting the phenomenon under study. Because social practices are contingent and context-bound their causes cannot be isolated from one another and attempts at manipulating them through controlled experiments would change the nature of the phenomenon under study. Although the elegance of the controlled trial can be attractive, the knowledge derived from such a methodological device that isolates causal forces is of little relevance to understand and orient social practices. The objectification of humans involved in practice inherent to the positivist epistemology makes little room for human agency, which is the capacity to exercise causal power and change one's situation. At best, in an empiricist, post-positivist perspective, one must develop a research posture that allows for opening the black box of the practice and examines how it shapes, and is shaped, through interactions with context (35).

The second assumption of positivist science untenable for health promotion is the externality and superiority of the knowledge detained and created by science. Research and researchers cannot be made totally invisible and external to the practices under study as those practices contain a subjective, symbolic dimension that can only be accessed through human interactions. In addition, to fully understand what shapes practice and its impact, the subjective knowledge that situates the practice in context is not less important than the objective knowledge of the researcher.

We suggest that these two epistemological postures, related to the objectification of humans and to the unique superiority of scientific knowledge, are incompatible with the social practices of health promotion. However, we do not suggest that all empiricist epistemologies such as post-positivism or critical realism should be excluded and that only subjectivist epistemologies should be valued. Recognizing the symbolic dimension of practice does not obliterate the causal power of physical, biological, psychological and social structures that shape health practices. As an applied field, health promotion research needs to elaborate an epistemological perspective that recognizes the multiplicity of these causal powers and the possibility of their interactions.

What also characterizes health promotion research is the fact that it radically accepts the complexity of situations (36). It is a question of going beyond methodological reductionism to shed light not only on the isolated facts, but also on their interactions and insertion in unpredictable and non-linear dynamics (37). To explain what complexity is, it is common to compare a complicated problem and a complex problem. On the one hand, sending a rocket into space can be considered a complicated problem. It requires a lot of operations, but these can be divided into discrete sets of actions with stable, predictable and linear consequences. When such a complicated problem is solved, it remains solved, and the solution can be successfully repeated. On the other hand, organizing a community or educating a child can be considered as complex problems. The relationships between actions and outcomes are mostly unpredictable and non-linear. Even if the organization of a community or the education of one child provides a meaningful experience, there is no guarantee of success for the future – that is, for the work with another community or another child. Community members, parents, teachers and children are active agents, whose behaviours continuously adapt in response to many interactions, generating different behaviours and outcomes.

Finally, a health promotion research epistemological framework also needs to account for the necessary dialogue between various forms of knowledge, the scientific knowledge derived from empirical and theoretical enquiries, the professional knowledge of those actively engaged in health promotion activity and the experiential knowledge of those whose health practice is at stake. Being able to learn from these different kinds of knowledge, acknowledging their respective fields of validity and limitations, and creating ways to put these sources of knowledge in synergy without compromising their specificity are among the key features of health promotion research (38).

Therefore, the field does not refer to a unique epistemology but integrates research that it has in common to take into account the complexity of situations on the one hand and to give a full place to a diversity of knowledge on the other hand within an ethical framework based on empowerment.

Structuring health promotion research

Figure 1 provides a snapshot of our vision of the state of development of health promotion research. It is an emerging distinct field in need of structuration to achieve stability and sustainability. Such structuration will facilitate the identification of the field and will generate the creation of a recognized identity as health promotion researchers. We suggest the framework would comprise three dimensions related to the object being researched, the purpose of the research and the knowledge created. The unique configuration of elements in these dimensions would constitute the pillars anchoring the field of health promotion research. Whereas the objects of research are relatively well-defined, the ethical and epistemological dimensions are still to be fully discussed and agreed upon.

Health promotion research has come of age. It is timely to structure this field. Such structuration efforts will be necessary to pursue the goal of developing a coherent cumulative knowledge base

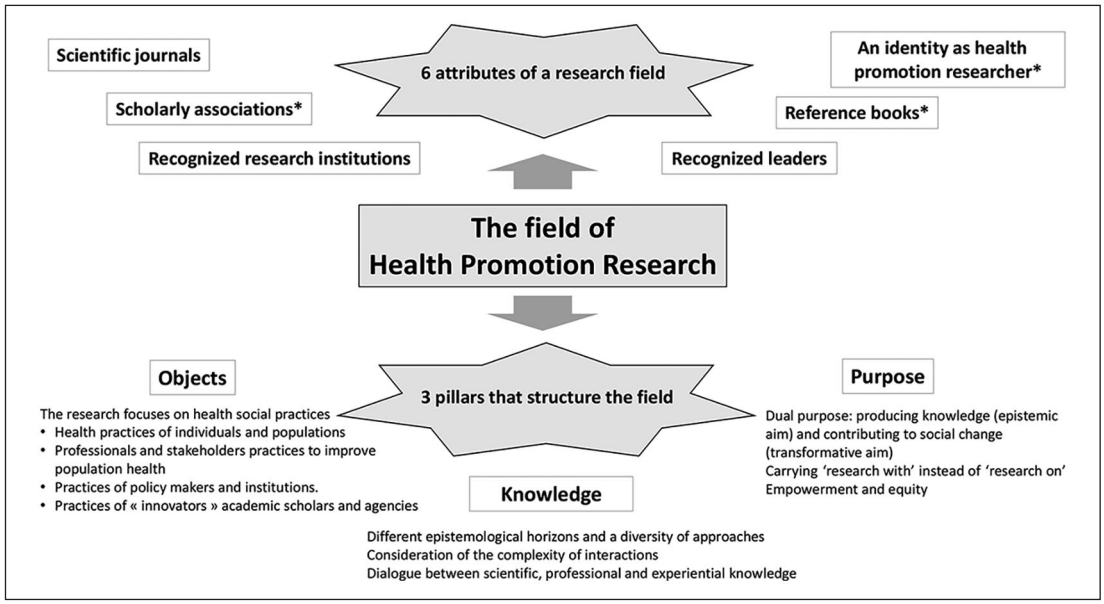

Figure 1. Structuring the field of health promotion research.
*Indicates criteria for a distinct research field not yet completely fulfilled in health promotion research.

relevant for health promotion practice and decision-making. To be true to the core values of health promotion, the process of structuring this multidisciplinary, applied and, often contested, field of scientific enquiry, cannot occur top-down through the authoritative writing of a handful of contributors. We believe that the past two or three decades of research conducted by several dozen research teams around the world constitute a fertile ground from which one can develop structuration principles and criteria that would reflect, and enhance, the distinctiveness of health promotion research. It is with this bottom-up process in mind that we created a call for contributions to our project of publishing the 'Global handbook of health promotion research', with the view that when researchers enter the field they will be equipped with some landmarks to help them navigate the messiness of the field. There exist other 'reference books' in health promotion, but there are very few in health promotion research and, to our knowledge, there is no handbook yet.

The goal was to bring together experts from different 'research traditions' that coexist in the field of health promotion. This handbook will cover the existing knowledge production and sharing practices, with the aim of defining the discipline and its agenda for future research and to better align research funding mechanisms with the needs of the field. In the call, we asked potential contributors to analyse an exemplar project from their practice focussing on what actually happened during the research process reflecting on the epistemological and ethical principles underlying their research practice.

We received more than 70 full chapters that we grouped according to which of the four areas of health promotion practice described above the research was about. These examples and analyses from the field will form volume 1 of the handbook: 'Mapping health promotion research'. Volume 2 of the handbook, 'Framing health promotion research', will be based on an analysis of chapters from part 1 and will draw the contours of the epistemological and ethical dimensions of a unified field of health promotion research as it is practiced by health promotion researchers. Finally, for volume 3, 'Doing health promotion research', we have invited some more seasoned colleagues, whose research is strongly associated with a specific epistemological and/or ethical approach. We asked them to write an

introductory-level chapter about this approach and to reflect on the epistemological and/or ethical health promotion research it contributes and how it shapes health promotion research distinctiveness.

The ultimate aim of this process is to contribute to the creation of a global community of actors engaged in knowledge production and sharing about health promotion. This will be accomplished through two complementary outcomes. The first will be a tangible product, a handbook that proposes a structuration of health promotion research that will enrich as the field grows. The second is the creation of a community of research hubs identified as contributors to this structuration process and as leaders for the development of health promotion research. To help mature this network into a scholarly association, the IUHPE, a partner in the production and diffusion of the handbook, is critical. As the only global organization of health promotion practitioners, decision-makers and researchers, the IUHPE is a natural home of applied researchers who need to be closely associated with practitioners and decision-makers to be able to conduct with health promoters and participate as innovators to the transformative health promotion agenda.

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ORCID iD

Louise Potvin https://orcid.org/0000-0001-7759-5952

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Original Article

Strengthening health promotion practice: capacity development for a transdisciplinary field

Stephan Van den Broucke

Abstract: The growing burden of non-communicable and newly emerging communicable diseases, multi-morbidity, increasing health inequalities, the health effects of climate change and natural disasters and the revolution in communication technology require a shift of focus towards more preventive, people-centred and community-based health services. This has implications for the health workforce, which needs to develop new capacities and skills, many of which are at the core of health promotion. Health promotion is thus being mainstreamed into modern public health. For health promotion, this offers both opportunities and challenges. A stronger focus on the enablers of health enhances the strategic importance of health promotion's whole-of-society approach to health, showcases the achievements of health promotion with regard to core professional competencies, and helps build public health capacity with health promotion accents. On the other hand, mainstreaming health promotion can weaken its organizational capacity and visibility, and bears the risk of it being absorbed into a traditional public health discourse dominated by medical professions. To address these challenges and grasp the opportunities, it is essential for the health promotion workforce to position itself within the diversifying primary care and public health field. Taking the transdisciplinary status of health promotion and existing capacity development systems in primary and secondary prevention and health promotion as reference points, this paper considers the possibilities to integrate and implement health promotion capacities within and across disciplinary boundaries, arguing that the contribution of health promotion to public health development lies in the complementary nature of specialist and mainstreamed health promotion.

Keywords: Health promotion workforce, discipline, capacity building

Introduction

Since the Ottawa Charter (1), the practice of health promotion has developed considerably. The health promotion workforce has expanded in size, diversity and competencies; graduate and undergraduate training programmes in health promotion have proliferated across the world; and health promotion organisations and institutions have been established, ensuring a structural basis for a diverse range of activities, programs and projects in a variety of settings, including schools, workplaces, communities, cities and health care organisations.

At the same time, the epidemiological, political and societal context for health promotion have also changed drastically. In the 35 years since the Charter, the world has witnessed a change of the burden of disease, with more chronic conditions and multimorbidity related to rising life expectancy in both developed and developing countries, a growing prevalence of injuries and violence, more stress and mental health problems, and widening health inequalities. Added to this are the health effects of spawning urbanisation, climate change and natural disasters, increasing anti-microbial resistance, and newly emerging communicable diseases like severe

Université Catholique de Louvain, Louvain-la-Neuve, Belgium.

Correspondence to: Stephan Van den Broucke, Psychological Sciences Research Institute, Université catholique de Louvain, Place Cardinal Mercier 10, Louvain-la-Neuve, 1348, Belgium. Email: stephan.vandenbroucke@uclouvain.be

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acute respiratory syndrome (SARS) and coronavirus disease 2019 (COVID-19). These developments take place in a broader societal context marked by financial crisis and austerity, and by an unprecedented revolution in communication technology. The latter provides a potentially powerful tool to increase peoples' access to knowledge and support systems that help to manage their health, but also gives rise to unequal access to health information, which widens the knowledge divide and boosts the influence of potentially health-damaging commercial determinants of health.

All of these changes put existing health systems under pressure. Whereas health services in most developed countries were set up to meet the needs of a demand-led health care with a focus on treatment, cure and care, the changing burden of disease makes these systems less effective and very costly (2). Yet, at a time when governments across the globe are trying to maximise the return on health spending, significant improvements in population health can still be achieved by addressing the factors that produce health, rather than just maintain it (3). Consequently, there is much to say for strengthening the role of public health and for emphasising preventive, people-centred and community-based health services, with a more prominent role for health promotion as part of the wider public health system (4).

In recent years, the idea of integrating prevention and health promotion in health systems and of strengthening the capacity of health systems to be more health promoting seems to be gaining ground. As a case in point, prevention and health promotion are included in the ten 'Essential Public Health Operations' (EPHOs) listed by the World Health Organisation (WHO)'s Regional office for Europe to guide assessments of public health capacities and services (5,6). In 2012, a mapping of the public health capacities in European Union (EU) Member States commissioned by the European Commission included health promotion and actions to address inequalities and the wider determinants of health (7), and, more recently, the European Observatory on Health Systems and Policies is leading a study on the effects of changing competencies and skill mixes across occupational groups within public health (8). These developments have important implications for the health workforce. As new tasks are added to existing professional roles and new profiles and collaborations emerge, the diversifying primary and public health workforce needs to adapt its competencies and skills. Since many of these competencies are at the core of health promotion, health promotion is increasingly being mainstreamed into modern public health, and integrated into competency and accreditation systems for health care and public health.

For health promotion, this development offers both opportunities and challenges. Opportunities, in the sense that a stronger focus on the enablers of health enhances the strategic importance of health promotion's whole-of-society approach to health care and prevention, showcases the achievements of health promotion and helps to build public health capacity through a 'health promotion lens'. But it also represents a challenge, as mainstreaming health promotion may weaken its visibility and bears the risk of it being diluted in a traditional public health discourse dominated by medical professions. This scenario was seen in the UK, where the mainstreaming of health promotion in the beginning of the millennium, although initially welcomed, reportedly resulted in a weakening of its organisational capacity and an absorption of health promotion concepts into an increasingly individualistic public health discourse (9–11).

This contribution considers the place of the health promotion workforce and of capacity building for health promotion within a diversifying primary care and public health field. Starting from a reflection about the place of health promotion in relation to public health, we will provide an overview of existing competency frameworks for primary and secondary prevention and health promotion, and consider possibilities for integration and implementation of these systems within and across disciplinary boundaries.

Health promotion as the new public health

Health promotion's relationship with public health is somewhat ambiguous. While health promotion practice is rooted firmly in public health and often seen as a part of it, it also represents a radical shift from traditional public health approaches, on account of its unique value system. As a reaction to the 'benevolent paternalism' that is believed to characterise traditional public health

thinking (12) in that it relies on the authority of experts and health professionals to determine what the population's health needs are and how they should be addressed (13), health promotion is much more value-driven and concerned with empowerment, equity and participation. Inspired by a salutogenic conceptualisation of health (14), it seeks to bring about positive changes in health. It revives the traditions of social medicine by paying particular attention to those that suffer disproportionately negative health outcomes, and tries to create a dynamic, participatory engagement with individuals and communities to enable them to take control over the determinants of their own health, emphasising that participation is an essential condition to sustain actions on health. These principles are highlighted by the three key health promotion strategies that are specified in the Ottawa Charter, i.e. advocacy to create the essential conditions for health, enabling people to achieve their full health potential and mediating between the different interests in society in the pursuit of health (15). In other words, health promotion takes participation, empowerment and equity seriously, which has profound implications for the way public health interventions are undertaken.

As such, health promotion is more than just a strategy, an 'essential operation', or, as the Bangkok Charter (16) puts it, a 'core function' of public health. Key scholars in the health promotion field argue that it actually represents the avant garde of public health, in the sense that it introduces novel ideas (17): it does more than just pay lip service to the idea that health is a social as well as a biological and psychological phenomenon, and shows the way from a pathogenic to a salutogenic focus on health. In fact, the mission to renew public health was already present in the Ottawa Charter, which after all was subtitled 'the move towards a new public health' (18).

This radical ambition to change public health does not always translate into the practice of health promotion, where tensions continue to exist between those who stay closer to health education and use models of behaviour change that are linked to biomedical positivist methods, and those who want to address the wider (social) determinants of health—the 'causes of the causes'—through structural interventions and measures that go beyond the individual. Yet, despite these differences, there is little doubt that health promotion stands for a profound change of the course of public health, through its emphasis on positive health, social influences on health, participation and empowerment. A 'new' public health that incorporates these values and principles needs to address the collective lifestyles of modern societies as well as the influence of the social and physical environment on the population's health and quality of life, while handing the control over these influences back to the people themselves and strengthening their capacities to deal with them.

The health promotion workforce

Unlike the medical workforce with its clearly established professions and career structures, the workforce for public health and health promotion is more difficult to describe and define. As a result, many different definitions coexist. Rotem et al. (19) distinguish public health workers from medical practitioners and define them as 'people who are involved in protecting, promoting and/or restoring the collective health of whole or specific populations', thus stressing their societal role. Beaglehole and Dal Poz (20) refer to the public health workforce as those 'whose prime responsibility is the provision of core public health activities, irrespective of their organizational base', highlighting that they can operate both inside and outside the health sector. In a similar vein, the Centre for Workforce Intelligence in the UK distinguish between a 'core' and a 'wider' public health workforce by defining the latter as 'all staff engaged in public health activities who identify public health as being the primary part of their role'. The US Institutes of Medicine include an educational component in their definition, and characterize the public health workforce as 'persons educated in public health or a related discipline who are employed to improve health through a population focus'.

These definitions focus on the public health workforce in general, without explicitly mentioning health promotion workers. As an evolving field, health promotion has a very diverse workforce, drawn from a broad range of disciplines. The Ontario Health Promotion Resource System, for instance, defines health promotion workers as 'those who work to promote health as defined in the Ottawa Charter regardless of professional

designation', adding that the definition includes 'people, organisations, and groups from various sectors', and that 'health promotion work may be paid or voluntary' (21). Although an increasing proportion of the health promotion workforce in industrialised countries has qualifications specific to the area, many people working in health promotion come from different educational backgrounds and received little formal training in health promotion (22). However, it is recognised that there is a specific body of skills, knowledge and expertise that represents, and is distinctive to, health promotion.

While the core of the public health or health promotion workforce are those who identify (public) health as their primary professional role, there is a growing awareness of the role for the 'wider' public health workforce, i.e. people who are not involved directly in public health or health promotion activities, who tend not to perceive themselves as being part of the public health workforce, but whose work nevertheless contributes to improving population health. This group includes health professionals such as midwives, community pharmacists or general practitioners (GPs) who may promote public health as a part of their jobs, as well as other professionals who are not working in the health sector but whose work can have a significant impact on population health, such as teachers, urban planners, architects, police or journalists (23,24). Their expertise may complement that of the core group of professionals to achieve a coordinated response to the social determinants of health. The core workforce can also act as a catalyst to support evidence-based interventions that are undertaken locally by competent health practitioners and the wider workforce.

The move towards expanding the public health workforce to include a wider group of professionals emphasises the multidisciplinary and diverse character of public health itself. Acknowledging and explicitly addressing the role of the wider workforce to promote population health is a necessary step towards dealing with the multidisciplinary nature of contemporary public health challenges. Yet a formally recognized core of public health and health promotion professionals remains necessary. An assessment of public health capacity in the EU in 2013 revealed that countries were generally stronger in traditional fields of public health, such as communicable disease control and vaccination, and weaker in addressing the social determinants of health and health inequalities (7). Thus, enhancing the capacity of the public health system to address emerging public health challenges cannot be achieved only by increasing the numbers of people who work in health, it also requires an investment in building the skills and competencies of that workforce.

Core competencies for health promotion

As a key dimension of the broader public health capacity (25), a well-trained health workforce has always been considered an essential condition for the delivery of effective health services. The diversification of the public health workforce and the growing recognition of prevention and health promotion therein provide opportunities to add new skills and tasks to existing professional roles end to enhance collaborations between professions. This has created a momentum to introduce the idea of core competences in health promotion and public health. Competences (or competencies — the terms are used synonymously) have been developed in the context of capacity building and workforce development as a means to develop a shared vision of what constitutes the specific knowledge and skills that are required for a given function. They can be defined as a combination of attributes (knowledge, abilities, skills and attitudes) that enable an individual to perform a set of tasks to an appropriate standard (26). In education, they can serve as an important reference to clarify expectations, define future professional needs for graduates, and provide a focus for the development of curriculum and course design.

Over the past decades, a number of reviews have been conducted of the competencies that are required for health promotion and for the related discipline of public health, in different regions across the world (26–28). As a result of these efforts, a consensus has been reached on an elaborate and detailed set of core competencies that health promotion specialists need to possess. These are set out in the Galway Consensus Statement (29,30), which served as a basis for the development of a comprehensive set of 68 professional standards for health promoters through the EU-funded CompHP project. The standards subscribe to the ethical values and principles of health promotion (belief in equity

and social justice, respect for the autonomy and choice of individuals and groups, and collaborative and consultative ways of working) and to a multidisciplinary health promotion knowledge base as guiding practice, specified and developed within the other core domains/clusters (enable change, advocate, mediate, communicate, lead, assess, plan, implement, evaluate and research). The International Union for Health Promotion and Education (IUHPE), as the main driving force for professionalisation of health promotion globally, has been instrumental in taking this work forward by developing an accreditation mechanism for health promotion specialists and university courses worldwide (31).

This accreditation system serves as a valuable inspiration for other public health areas, where core competencies, standards and accreditation mechanisms are also being developed (32–34). For instance, in the UK, the Public Health Register requires public health practitioners wishing to apply for registration to go undergo a rigorous process of assessment to demonstrate their knowledge, understanding and application of 34 standards related to 70 core competencies categorized within 13 functions. The 'public health function' referred to in these standards is defined in the Public Health Skills and Knowledge Framework 2016 as 'improving and protecting the public's health and reducing health inequalities between individuals, groups and communities, through co-ordinated system-wide action (35)'. As such, the core competencies that have been, or are being, developed for public health also refer explicitly to health promotion. Likewise, in Canada a group of health promoters within Health Promotion Canada (HPC) developed a set of specific health promoter competencies, building upon the core competencies for public health developed by the Public Health Agency of Canada (PHAC), but providing greater detail regarding the knowledge, skills, and abilities necessary for the practice of health promotion. The competencies come with a series of tools to support the use of the health promoter competencies by students, practitioners, managers and academic instructors.

While an increasing number of countries have specified competencies for public health and health promotion practice, the implementation and use of these competency frameworks varies greatly. Some countries specify a minimum level of competency expected of all public health workers, while others have different expectations for varying seniority (36).

An element of debate is also whether standards and accreditation mechanisms are a necessity to achieve proficiency in the core health promotion competencies. Whereas the Galway Consensus Statement recommends that each country or region would develop or adopt quality assurance mechanisms in accordance with the prevailing political, economic or cultural context, health promotion professionals and organisations in some countries have taken a cautious stance on this issue, fearing that the process that is required for health promotion to become a formally accredited and regulated profession could be rigorous, time-consuming and potentially divisive (35). An alternative approach could then be not to promote the competencies as a step towards the mandatory accreditation of health promoters, but as a way to inform and stimulate dialogue towards agreement on a requisite skill set for health promotion training and practice.

Despite these different viewpoints on the way to roll out the core competencies, it is clear that the use of a consensual, comprehensive set of professional standards for health promotion professionals is generally welcomed. The core competencies can play a key role in the underpinning of future health promotion training and course development, continuing professional development, and accountability to the public for the standards of health promotion practice. In a broader sense, they can also contribute to the consolidation of health promotion as a specialised field of practice.

Health promotion as a discipline and profession

The move towards an integration and mainstreaming of health promotion principles and strategies into public health offers unique opportunities to bring in a health promotion perspective and reorient public health interventions more towards addressing the social determinants and other enablers of health, to emphasise the strategic importance of a positive and whole-of-society approach to health care and prevention, and to strengthen the importance of participation

and empowerment of individuals and communities. It also gives a chance to bring a health promotion perspective to public health capacity building (37) by introducing specific health promotion competencies into public health professional standards and accreditation systems. But mainstreaming health promotion can also challenge its uniqueness. Experiences in the UK, Canada and Australia have shown that mainstreaming the ideas and strategies of health promotion in the early 2000s led to their absorption into a traditional, individualized public health discourse, dominated by other, usually medical, professions (11), and even to the disappearance of the term 'health promotion' itself: in England, it was replaced by 'health development' and, later on, by 'health improvement'; in Canada the term 'population health' was introduced as an alternative, and in Australia the term 'preventative health'. Although this change of names and terminology for reasons of political convenience obviously did not imply the loss of health promotion expertise (specialists trained in health promotors continued to work in the public health systems and even held leadership positions), it did result in a loss of visibility and identity. The same has been noticed in international agencies like WHO and the Pan American Health Organisation (PAHO), where mainstreaming health promotion as a cross-cutting topic across the organisation resulted in a loss of dedicated champions, visibility and power (38). This may have as a consequence that the importance attributed to health promotion within governmental and academic institutions also decreases, resulting in a reduction of capacities to train new scholars, carry out research and interventions, and foster collaboration and exposure to innovative ideas (39). Interestingly, in Canada the term health promotion has recently been re-introduced, through the establishment of HPC in 2016. In the UK, on the other hand, the plan to name the newly established governmental department that hosts the former Public Health England health improvement staff as 'Office for Health Promotion' was not retained, and the department is named 'Office for Health Improvement and Disparities' instead.

As argued by Van den Broucke (37), this risk of identity loss can be attributed partly to the unclear disciplinary status of health promotion and the fuzzy professional identity of health promotion workers. A field of study is considered a discipline when it has its own specific knowledge domain, history, value base, traditions, codes of conduct and preferred research methods; to be considered a profession, it needs a recognised workforce, overseen by a body that implements professional competency and accreditation methods (38). Health promotion certainly has many of the attributes of a discipline: it has its own set of concepts and values, crystallised around holistic and emancipatory approaches that promote health equity, social justice, participation and empowerment; it is well grounded in relevant theory (40,41); it applies a methodology that involves a shared understanding of what constitutes good practice; and it supports a notion of 'evidence' that is wider than that of public health and medicine in order to capture the complex interactions between various determinants of health, situated at different levels (42). But health promotion is not based on a single paradigm with its own epistemological, theoretical and methodological foundations; it borrows its theoretical and disciplinary roots from longer established disciplines, such as sociology, psychology, education science, political science, communication science, marketing and ethics (41,43). As such, health promotion is essentially transdisciplinary.

Health promotion also meets some, but not all the criteria to be considered a profession. There is indeed a large offer of university training programmes and courses, handbooks, journals and conferences dedicated to building the competencies of the health promotion workforce, as well as core competency systems with professional standards and accreditation systems for health promotion specialists or training courses that are gradually being implemented. There is also a global network of governmental and nongovernmental organizations that support the development and implementation of health promotion programs. Yet in most countries there is no distinctive institutional structure or professional body that oversees health promotion practitioners and guarantees that their qualifications meet the agreed-upon standards, which means that, in practice, anyone can call him/herself a health promotion professional (43).

Mainstreamed versus specialist health promotion

The transdisciplinary nature of health promotion and its status as an emerging (as opposed to an established) profession make the goal to make public health more health promoting challenging. While there is an opportunity to integrate the concepts, values, strategies and methods of health promotion into the practice and teaching of public health, this should be done without sacrificing its identity and status.

To achieve this double-edged goal, it may be important to differentiate more clearly between specialist and mainstreamed health promotion. The first refers to a scholarly body of knowledge and practice, with its own specialists contributing to the field at academic and professional levels, while the second designates health promotion as a social movement, embedded in the work of people who work to promote health as defined by the Ottawa Charter, regardless of their professional designation. Health promotion specialists, both academics and professionals, may work in organisations dealing with various aspects of health, while mainstreamed health promotion can also take place outside the health sector, for example, in schools, sport and fitness settings, workplaces, prisons, etc. According to Davis (38), the training backgrounds of health promotion specialists are manyfold, and vary in different parts of the world. In North America, for instance, health promotion specialists often have a training in nursing, social work or education, whereas in European countries like France and the Netherlands they are often trained as health educators. In Africa and South East Asia, on the other hand, health promotion programmes are led mostly by professionals trained in public health and implemented by health education and communication specialists. Academic health promotion is dominated mostly by the disciplines of public health, health education and health psychology, whereas health promotion in practice is shaped by public health and education professions (44). These differences reflect the complexity of the health promotion specialist profile and, as such, underscore the need for comprehensive, agreed-upon professional standards for health promotion professionals.

The complementary nature of specialist and mainstreamed health promotion can be the key to the contribution of health promotion to the development of public health. Mainstreaming health promotion can ensure that the holistic and empowering approach of health promotion, with its emphasis on equity, social justice and participation, finds its way in the broader public health domain, and that it is reflected in the training curricula and professional standards of public health specialists. On the other hand, training and supporting a core body of health promotion specialists within academia, policy and practice settings can help to maintain the identity and traditions of the field, and further advance the body of knowledge, values, competencies and research methods that make health promotion unique.

Conclusion: capacity development for a transdisciplinary field

The contribution that health promotion can make to health care and public health answers a true academic and societal need. In the wake of the epidemiological, political and societal changes the world has seen over the past decades, health systems need to adjust their problem-oriented, technical and top-down approach to addressing health problems, and focus more on health as it is experienced by the people themselves. To do so, public health and health care workers need to become more competent at acknowledging and attending to the needs of individuals, organisations, communities and networks, and at enabling them to promote health in a self-determined and sustainable manner.

Health promotion is the only 'specialism' within the health system that has these competencies, and that has the professional and organisational capacity to continually develop, update and disseminate them. In this way, health promotion specialists need to advance the knowledge, values, competencies and research methods of health promotion and train, support and build the capacities of not only other health promoters, but also of a widening group of other health workers. The continuing development of health promotion as a transdisciplinary field of practice can thus nurture the broader group of mainstreaming health promoters, without losing its unique identity.

To direct and guide this process of competency development, comprehensive systems of agreed-upon core professional competencies and

professional standards for health promotion are extremely valuable. The core competencies, professional standards and accreditation systems developed through the CompHP project, the UK Public Health Skills and Knowledge Framework, and HPC, which all subscribe to the values and principles of health promotion, not only represent a major driving force for the further professionalisation of health promotion workers, but are also instrumental to integrating the concepts, values, strategies and methods of health promotion into the practice and teaching of public health.

The development and implementation of core competencies for health promotion as a means to enhance the professionalisation of health promotion and to strengthen its role within public health should be considered as a part of a broader capacity building process. As pointed out by Aluttis et al. (25), public health and health promotion competencies are to be distinguished from capacities: the first are concerned with identifying, describing, assessing and ascertaining the knowledge, competencies and values that are required of public health and health promotion professionals as a basis to guide professional training; the latter refer to a broader concept that looks at the characteristics of the system for public health as a whole. Workforce development, of which core competencies are an important element, is but one of a series of dimensions that make up the capacity of a public health system, next to knowledge development, resources, organisational structures, partnerships, leadership and governance, and the country-specific context (25). Existing frameworks for public health and health promotion capacities highlight the importance of all these dimensions to build effective public health systems, and note that they are often interdependent. This means that the development of the public workforce is only one — albeit important — way to make the shift towards a more prominent role for health promotion in public health. It also means that the chances of successfully strengthening the health promotion workforce depend on other factors, such as a leadership and governance that is supportive of health promotion, allocation of sufficient financial resources, adequate institutional and organisational capacity, research in health promotion, and formal and informal partnerships. Only if these capacities can be strengthened, will health promotion flourish as a transdisciplinary field of practice and as an emerging profession that can help build more preventive, people-centred and community-based health systems.

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ORCID iD

Stephan Van den Broucke https://orcid.org/0000-0002-9090-8877

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The IUHPE Health Promotion Accreditation System – developing and maintaining a competent health promotion workforce

Barbara Battel-Kirk[1], Shu-Ti Chiou[2], Liane Comeau[3], Ronan Dillon[4], Kirsten Doherty[4], Andrew Jones-Roberts[5], Tia Lockwood[5], Marguerite Claire Sendall[6], Viv Speller[7] and Margaret M Barry[8]

Abstract: This commentary reports on the development and implementation of the competency-based IUHPE Health Promotion Accreditation System in the context of workforce capacity as a key activity of the International Union for Health Promotion and Education (IUHPE). The process of developing the System is described, including how it built on, and added to, international research and experience in competency-based approaches to health promotion. An overview of how the System works, its current status and future plans, is presented. Evidence of the positive impact of the System to date, in particular in the context of health promotion education, is considered.

Keywords: Accreditation, capacity building (including competencies), workforce development

Background

The IUHPE Health Promotion Accreditation System[1] builds on definitions of health and health promotion as outlined in the Ottawa Charter (1) and subsequent charters and declarations. The System is grounded in the ongoing work of the International Union for Health Promotion and Education (IUHPE) in developing global workforce capacity and draws on international experience and research (2–7) in using competency-based approaches in health promotion.

Building a competent health promotion workforce is key to delivering on the vision, core values, principles, political vision, and strategic objectives of health promotion as outlined in World Health Organization (WHO) charters and directives, and in international agreements and national policies (2–7). Workforce capacity development is essential to the sustainability and future development of health promotion and critical to the effective translation of health promotion policy and research into effective practice (2–7). Developing capacity for health promotion at local, national, regional and global levels has long been a core activity of the IUHPE. 'Capacity building, education and training' is the focus of one of the IUHPE global vice presidents and workforce development is prioritised in previous and current strategic plans.

However, health promotion globally is an evolving field with a diverse workforce drawn from a range of disciplines operating in a variety of settings and political, economic and social contexts (2–7). The diverse nature of the workforce underscores the importance of clearly articulating the unique

1. BBKConsultancy, Omeath, Louth, Ireland.
2. National Yang-Ming University, Taipei.
3. IUHPE, Montreal, Canada.
4. Association for Health Promotion Ireland (AHPI), Dublin, Ireland.
5. Australian Health Promotion Association, Keswick, SA, Australia.
6. Queensland University of Technology, Kelvin Grove, QLD, Australia.
7. Health Development Consulting Ltd., Waterlooville, Hampshire, UK.
8. National University of Ireland Galway, Galway, Ireland.

Correspondence to: Barbara Battel-Kirk, BBKConsultancy, Lisieux, Omeath, Louth RBT 1909, Ireland.
Email: bbkconsultancy@eircom.net

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contribution that health promotion makes to population health improvement, including in attaining Sustainable Development Goals (8) and addressing specific threats to health such as noncommunicable diseases (9) and the COVID-19 pandemic (10).

Within the context of workforce capacity development, the identification of competencies, standards and accreditation processes provides a shared vision of what constitutes the specific knowledge and skills required for effective and ethical practice (2–7). Competency-based approaches have been used in health promotion over the past three decades (2–7) and have been endorsed by the IUHPE (e.g., 11). In 2008, the IUHPE was a key actor, together with the Society for Public Health Education (SOPHE), in convening a global conference focusing on developing competencies and competency-based accreditation for health promotion – the Galway Consensus Conference (6,7). In preparation for the conference, papers were commissioned to inform the deliberations that included state-of-the-art reviews of the literature related to competency-based quality assurance in health promotion and related disciplines globally.[2]

Drawing on the international literature, the core competencies delineated at the Galway Consensus Conference (12) and on research undertaken by the IUHPE (13,14), a competency-based framework for health promotion was drafted in 2009. This framework formed the basis for a successful bid for funding from the European Union to develop the 'CompHP Project' (4). The project aimed to develop competency-based standards and an accreditation system for health promotion practice, education and training in Europe, with the IUHPE as a core project partner. The project took a staged, multilevel approach to building consensus on core competencies (15,16), professional standards (17,18) and an accreditation framework for health promotion (19,20). Each stage of the project was reviewed by an international advisory group of experts with experience in competency-based approaches to health promotion. Although focused in the European region, the work of the project thus drew on and added to the knowledge base and experience of developing competency-based quality assurance in health promotion globally (4).

In 2012, the resulting CompHP Accreditation Framework (19) was piloted and operationalised as the European Health Promotion Accreditation System from 2013 to 2016 (21). In 2016, in response to proposals from other IUHPE regions, the System was expanded to the global level and was formally launched as the IUHPE Health Promotion Accreditation System at the 22nd IUHPE World Conference.

How the System works

The System provides professional recognition of health promotion courses and practitioners that meet the agreed criteria. Formal recognition of professional education for professional practice and statutory or voluntary registration of practitioners is common for many professional disciplines globally. Statutory registration is legally established, usually at national level. In other circumstances, such as is the case in the System, professional recognition of educational courses and practitioners comprises a voluntary commitment to maintain agreed quality standards.

Registration within the System is viewed as a 'first step' towards statutory recognition of health promotion practitioners in some countries with established levels of health promotion capacity. However, in countries with less well-developed health promotion capacity, registration is viewed as a valuable '*added*' title for practitioners with other professional titles rather than delineating a specific health promotion professional identity (22).

Practitioners registered within the System receive the title *'IUHPE Registered Health Promotion Practitioner'* and accredited courses are described as an *'IUHPE Accredited Health Promotion Course'*.

In addition to providing recognition for practitioners and courses, the System provides:

- clear, agreed guidelines and quality standards for the health promotion knowledge, skills and values required to practise effectively and ethically;
- a basis for quality assurance in health promotion practice, education and training;
- accountability to the public through the registration of health promotion practitioners;
- assurance that accredited health promotion courses provide graduates with the knowledge and skills required for effective practice and that awards are validated based on agreed criteria;

- facilitation of movement of employment through the use of agreed registration procedures;
- greater recognition and visibility of health promotion and the work done by health promotion practitioners;
- a reference point for employers in recruitment and selection of health promotion practitioners.

The structure of the System comprises a devolved model within which National Accreditation Organisations (NAOs) are approved by the IUHPE Global Accreditation Organisation (GAO) to register practitioners in their catchment area using the agreed competency-based criteria and procedures. In countries where no NAO exists, practitioners can apply to the GAO, and the accreditation of courses, irrespective of their location, is also managed at the global level.

Current status

Currently, the countries with approved NAOs (Australia and Ireland) have the highest rates of practitioner registration, with practitioners also registered in Italy, Nigeria and the UK. There are accredited courses in Australia, Estonia, Finland, Ireland, Italy, Portugal, the Netherlands and the UK.

The high level of interest in, and uptake of, registration in Australia is attributed by the chair of the NAO to the Australian Health Promotion Association (AHPA)[3] and its members' previous experience in developing and implementing health promotion competencies (2,3). The ability of the NAO, established in 2017, to operate successfully at minimal cost is credited to the AHPA's willingness to invest time and resources in establishing and promoting it, together with a culture of volunteering within the Australian health promotion sector.

The Association for Health Promotion Ireland (AHPI)[4] was approved as an NAO in 2017. The NAO promotes registration through newsletters and workshops. The NAO also provides continuing professional development (CPD) opportunities that are structured around the System's requirements for registration and re-registration. The long-term aim is to raise the status of health promotion practitioners in Ireland as registered members of an established global professional group and promote reference to competencies and registration in recruitment for health promotion posts in Ireland.

There is ongoing discussion on developing an NAO in a number of countries, including in Canada, Italy, Israel and New Zealand.

Impact of the System

Recent research (22,23) suggests that the formal recognition of health promotion competence offered by the System provides a valuable mechanism for capacity development across different health promotion contexts and systems. For example, in the context of the System, the implementation of health promotion competencies has been instrumental in promoting quality assurance of practice, education and training. In particular, the System has informed curriculum development in health promotion education and training (22,23), thus ensuring that the next generation of health promoters has the right mix of skills and knowledge required for effective and ethical practice.

Planning for the future

While much has been achieved in developing and implementing the System, there have been challenges, not least the limited resources available. As the System develops, the cohort of volunteers available to undergo training as assessors and serve on the committees that form the participative structure of the System will increase, addressing one element of the resource gap. Increased uptake should also result in greater revenue, allowing for more administrative support. Issues of language and translation pose challenges due to differences in cultural and linguistic interpretations of key concepts and core words associated with health promotion and competency-based approaches (22). Future transitions of the criteria and processes of the System will therefore need to be a cooperative endeavour between skilled translators and experts with a solid grounding in health promotion.

Research findings (22,23) indicate that a key element in successful implementation of health promotion competencies is understanding the relevant political, social, cultural, professional and educational contexts within which health promotion is operationalised. These findings are informative when utilising and marketing the competency-based System as a tool for strengthening health promotion capacity, both in countries where capacity levels are

low and where levels are higher. For example, the System can underpin efforts to achieve greater recognition of health promotion in countries with less well-developed capacity. In countries with established health promotion capacity, the System can help maintain and expand the workforce and ensure that health promotion is practised in a competent manner. Understanding of relevant contexts is also key when developing targeted marketing strategies to secure 'buy-in' for the System from key stakeholders, including policymakers, academic institutions and employers. This is a critical component in progressing the implementation of the System globally (22,23).

Informed by the experience gained to date and based on research findings, all aspects of the System have recently been updated by an IUHPE action group. The group is now focused on supporting the development of new NAOs and marketing the System to key target audiences globally.

Conclusion

The development and implementation of the IUHPE Health Promotion Accreditation System provides a competency-based platform for quality assurance in practice, education and training. Research demonstrates that the System contributes to workforce capacity development, in particular through its positive impact on health promotion education. Future development of the System will require not only resources but comprehensive understanding of the health promotion contexts within which it is operationalised.

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ORCID iDs

Barbara Battel-Kirk https://orcid.org/0000-0001-9798-7515
Shu-Ti Chiou https://orcid.org/0000-0002-6994-1891
Margaret M Barry https://orcid.org/0000-0002-9464-7176

Notes

1. https://www.iuhpe.org/index.php/en/the-accreditation-system
2. The majority of these papers can be found in:
   - *Glob Health Promot.* (2009) 16 (2) – https://journals.sagepub.com/toc/pedb/16/2
   - *Health Educ Behav.* (2009) 36 (3) – https://journals.sagepub.com/toc/hebc/36/3
   - *Health Educ Behav.* (2009) 39 (6) – https://journals.sagepub.com/toc/hebc/39/6
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From health education to digital health literacy – building on the past to shape the future

Don Nutbeam

Abstract: Health education has continuously evolved and taken several distinctive forms over the decades. The emergence of new concepts such as health promotion and health literacy have helped to shape and refine our understanding of how the purpose, content and methods of health education can adapt with to new public health methods and priorities. Viewing health education through the lens of health literacy has been particularly helpful in differentiating between traditional task-focused health education, and skills-focused health education designed to develop more generic, transferable skills. The advent of digital media has enabled unprecedented access to health information but brought with it new challenges. Managing the volume of available information, and assessing its quality and reliability have become essential digital health literacy skills in the information age. As health educators we need to continue to adapt our practices to these new opportunities and understand the challenges that come with them.

Keywords: Education (including health education), health literacy, health promotion, e-health, communication including social marketing, education campaign, media communications

Health education has been an essential and enduring tool in public health for more than a century. This role has been built on the simple proposition that the public should have access to health information in a form that helps them to make the best decisions for their personal health and that of their family and community. As a concept and discipline, health education has continuously evolved and taken several distinctive forms over the decades. The International Union for Health Education (IUHE) was established 70 years ago as an independent global network of people and institutions committed to advancing health education in their communities and populations. It too has evolved in its form and purpose.

The Union has always been at the forefront of professional (and public) debate about concepts and principles for improving the health of populations. This was evident in the mid-1980s during a time of substantial and sometimes passionate debate about the emerging concept of health promotion and its relationship with the established practice of health education (1). These debates featured in the 12th IUHE World conference in Dublin, and continued through to the 13th and 14th World Conferences in Houston, in 1988, and Helsinki in 1991. In between the Dublin and Houston Conferences, the World Health Organisation (WHO) organised its first international conference on health promotion in Ottawa, Canada. This Conference resulted in the Ottawa Charter for Health Promotion (2).

That Charter promoted a paradigm shift in the way in which public health issues were conceptualised – its sub-title was 'the move towards a new public health'. It prioritised five strategies: build healthy public policy; create supportive environments for health; strengthen community actions; develop personal skills; and reorient health services. These

School of Public Health, University of Sydney, Sydney, NSW, Australia.

Correspondence to: Don Nutbeam, School of Public Health, University of Sydney, Sydney, NSW 2006, Australia. Email: don.nutbeam@sydney.edu.au

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strategies have provided an enduring influence, guiding the development of the concept of health promotion and shaping public health practice in the subsequent 35 years.

Although phrases such as 'full and continuous access to information' and 'learning opportunities for health', and the term 'education for health' are used, the specific term 'health education' is conspicuously absent from the Charter. This absence represented a low point in appreciation of the importance of health education as the cornerstone of so much of what was advocated by the Ottawa Charter (1).

At that time there was a sense of frustration that public health as a discipline had become largely medicalised, with a strong focus on personal health risk and 'lifestyle choices'. Health education was conceived to be correspondingly narrow in its content and mode of delivery. At the time there was considerable enthusiasm for the use of mass communication and emerging social marketing techniques to deliver over-simplified messages exhorting people to 'look after yourself' (3). This style of health communication was especially popular with the governments of the day in many countries (and remains popular today for some).

Regrettably, this represented an over-simplified dichotomy between health promotion and health education. It contributed to an unhelpful breakdown in relations between people and organisations who were already deeply invested in health education, and those who were advocating for the paradigm-shifting 'new public health' in the form of health promotion.

The International Union was not immune from this and engaged in its own lengthy processes that eventually led to the organisation being renamed the International Union for Health Promotion and Education (IUHPE). This apparently simple change masks the fierce and sometimes divisive debate that preceded it over a number of years.

Fortunately, these divisions have mostly faded. There is a more sophisticated understanding of how the purpose, content and methods of health education can fit comfortably with the 'new public health' strategies that were promoted following the Ottawa Charter. In reality, it had always been the case that running alongside health education directed towards changing personal health behaviours, there has existed a decades-old tradition of health education supporting personal empowerment, and community development (see, for example, Wallerstein and Bernstein (4) and Israel (5)). The content and purpose of health education has regularly been oriented to exposing the social determinants of health, advocating support for public and corporate policy change, and mobilising community activism (see, for example, Farrer (6) and Dorfman (7)).

The emergence of the concept of health literacy over the past 25 years has helped to bridge the perceived differences between health education and health promotion. Health literacy is an evolving discipline that has excited much interest from researchers, practitioners and policy-makers (8). It has long been proposed as a measurable outcome to health education, and as a way of measuring the impact of health education that fits into a broadly based model of health promotion (9). Health literacy has been defined and conceptualised in multiple ways (10,11), but is ultimately based on observable knowledge and skills that are moderated by environmental context and personal circumstances (12,13). Knowledge and related skills can be improved and developed through effective health education. Health literacy has been enthusiastically embraced within IUHPE with an active Global Working Group on health literacy that has developed an IUHPE position statement on 'Health Literacy: a practical vision for a health literate world' (14).

Viewing health education through the lens of health literacy has been particularly helpful in differentiating between task-focused and skills-focused health education. Task-focused health education tends to be more limited in scope and intention – providing a narrow range of information designed to support specific responses (for example, medication adherence, or personal behaviour change). This traditional, goal-directed role for health education has always been a foundational tool for improving health in populations.

By contrast, skills-focused health education is designed to develop more generic, transferable skills. Such skills equip people to make a range of more autonomous decisions relating to their health; to adapt their decision-making to changing contexts and personal circumstances; and to respond to a broader understanding of health and its determinants. These transferable skills have been described as

'interactive' and 'critical health literacy', and connect closely to modern concepts of health promotion (15–17). By focusing attention on skills development and on empowerment, the concept of health literacy builds on the long history of health education in supporting the improvement of personal skills, community development and social activism. It also sharpens attention to differences in the purpose and content of health education.

As our understanding of health literacy has improved, there are a growing number of studies based on health education and/or patient education designed to improve health literacy and related health outcomes. Several reviews of these interventions have shown that the majority have been in clinical settings, generally designed to mitigate the effects of low health literacy on patients' ability to understand medical conditions and respond correctly to instructions relating to their healthcare – supporting functional health literacy rather than developing transferable skills (18,19). Reports on health literacy interventions with community (non-clinical) populations are less common (20,21). Taken as a whole, this research has provided consistent and mostly compelling evidence of the feasibility and potential effectiveness of health education to improve health literacy. This includes interventions to develop functional skills to change behaviour and manage medical requirements, as well as the development of transferable health literacy skills. These transferable skills have both immediate application and also enable people to engage in more interactive and critical ways with information about their health in a wide variety of situations. That said, it is clear from the existing reviews that more work needs to be done in the development of replicable interventions, improved measurement of health literacy and use of more robust evaluation methodologies.

This growing body of evidence also serves as a reminder that people gain access to information about their health from many and varied sources – not only planned communications from health professionals and health organisations, but also through print and broadcast media, and from family and social groups. More recently, these traditional sources of information have been radically disrupted by an explosion in the availability of health information from digital and mobile sources, especially in the past decade.

As methods for mass communication have evolved from the traditional print and broadcast media to the digital and mobile, so too have health education methods evolved. Digital technologies have created an opportunity for health professionals and health organisations to communicate directly with large numbers of people in real time (22). We are now at a stage where there are hundreds of thousands of websites and smartphone apps providing access to health information. This digital revolution in communication has offered unprecedented opportunities to personalise information, help people set health goals and provide feedback in real time.

Several reviews of digital health interventions have demonstrated the feasibility and potential effectiveness of eHealth and mHealth interventions for a range of health conditions in low-, middle- and high-income countries (23–25). As a counterpoint, there is also a significant body of research indicating that information created for the general public is not understandable or actionable for a majority of people (26,27). Too often health information, even from the most reliable and trustworthy sources, is made available in a form that does not match the health literacy and/or cultural preferences of the intended recipients.

This same technology has not only made it easier to access quality health information, but also provided easy access to information and opinion that is inaccurate, sometimes deliberately misleading and often driven by commercial motive (28). For people searching for health information, this has required the development of different skills, especially those required to assess the relevance and trustworthiness of the many and varied sources of health information. These skills are sometimes referred to as digital health literacy.

The COVID-19 pandemic has provided numerous examples of the public being faced with an overabundance of information (29). This has made it difficult for many to access, understand and act on health information at the time they needed it most. This challenge has been amplified by the widespread availability of both inaccurate and deliberately misleading information on the causes and consequences of COVID-19. This has required from governments and health organisations both a response to the public need for understandable information, and action to address the misinformation

and myths that have the capacity to derail broader public health actions to control the pandemic (30).

A recent review of online health information and misinformation by Swire-Thompson and Lazer describes how the promise of digital communication is being severely compromised by reliability of online information. The review suggests dual strategies for improving both the quality and accessibility of the online information ecosystem; and assisting the general population in effectively navigating to trustworthy sources of information. The authors identify some examples of interventions that are incorporating these digital health literacy skills (28), and other examples are emerging, especially in Europe (31).

Health education has long been the cornerstone of public health, and has evolved as new ideas have emerged. Health education content, methods and media have not only been used to encourage individuals to change their behaviours, but also to develop enduring, transferable skills. These health literacy skills enable people to access and apply health information to improve personal, family and community health across the life-course.

The advent of digital media has enabled unprecedented access to health information but brought with it new challenges. Managing the volume of available information, and assessing its quality and reliability have become essential digital health literacy skills in the information age. As health educators we need to continue to adapt our practices to these new opportunities and understand the challenges that come with them. As the digital revolution offers unprecedented opportunities to reach people directly and to personalise our health messages, we should remind ourselves of the important role of health education in exposing the social determinants of health, advocating for policy change and supporting community development.

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ORCID iD

Don Nutbeam https://orcid.org/0000-0001-6497-2827

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Visioning the future of health promotion

Ilona Kickbusch

Abstract: COVID-19 has shown us clearly that the world must commit to a transformative approach that promotes health and wellbeing. Living in the Anthropocene – an epoch defined by human impact on our ecosystems – moves us into unknown territory. The challenge is to find a way of living that aims to meet the needs of all people within the means of the living planet. We will require foresight, agility and resilience to be well prepared. The global risks we face are enormous and they are interconnected – yet the opportunity to accelerate change for the better is extraordinary as well. We have models, knowledge and technologies at our disposal that could significantly improve health and wellbeing and create fairer and more sustainable societies – yet they have not been used widely to serve the public purpose and to address inequities.

Keywords: Transformative approach, sustainable development goals, complexity, wellbeing, health promotion

Being transformative

COVID-19 has shown us clearly that the world must commit to a transformative approach that promotes health and wellbeing. Living in the Anthropocene – an epoch defined by human impact on our ecosystems – moves us into unknown territory (1). The impact of the COVID-19 pandemic reinforces this view (2).

The challenge is to find a way of living that aims to meet the needs of all people within the means of the living planet. We will require foresight, agility and resilience to be well prepared. The global risks we face are enormous and they are interconnected – yet the opportunities to accelerate change for the better are extraordinary as well. We have a blueprint – the Sustainable Development Goals (SDGs) – as well as models, knowledge and technologies at our disposal that could significantly improve health and wellbeing and create fairer and more sustainable societies – yet they have not been used widely to serve the public purpose and to address inequities (3).

The way forward – towards a framework for a new public health for the 21st century – must fit the time and its challenges: these are inequality, climate crisis, pandemics, digitalization and a weakening democracy. We need to adapt our basic approaches and action areas of health promotion to the drivers of change in a global risk society (4). Transformation happens at many levels; over the last years it has taken place especially at the city level as well as through new technologies (5). The ethos and the five strategies introduced by the Ottawa Charter for Health Promotion (6) remain valid, but they need to be implemented creatively in a very different world defined by rapid political, social, economic and environmental change as well as deep technological and digital transformation. This makes it necessary to rethink and adapt them.

The 17 SDGs have been an important step in setting global priorities and highlighting how the challenges interrelate. The Global Conference on Health Promotion in Shanghai 2016 reiterated this close interface between the SDGs and health promotion, as shown in Figure 1.

Global Health Center, Geneva, Switzerland.

Correspondence to: Ilona Kickbusch, Global Health Center, Chemin Eugene Rigot 2, Geneva, 1211, Switzerland. Email: kickbusch@bluewin.ch

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Figure 1. World Health Organization (WHO) infographic: Promoting health, promoting sustainable development. Source: WHO, Geneva (2016). Available from: https://www.who.int/healthpromotion/conferences/9gchp/infographic_health_promotion.jpg?ua=1OpenAccess

Embracing complexity

The SDGs clearly embrace complexity – and they show how all SDGs impact on health. This allows for transformative agendas in global health such as ONE HEALTH approaches or the strong commitment to universal health coverage (7). But there are also other important mind shifts that health promotion must consider as it addresses the priority of integrating the health equity and the sustainability challenge. Health promotion has been transformative in content and process from its inception, and this has often worked against the acceptance of health promotion approaches in the past (8). In particular this was due to a lack of understanding of the interconnectedness of influences and of the time frames within which success can be measured. Health promotion must focus on the patterns that create or hinder health and wellbeing, which for many people cumulate either positively or negatively over time and the lifespan (9). This is most obvious in the interface of factors such as the distribution of wealth, knowledge and life chances (10).

Yet such a long-term view runs counter to the short-term orientation of measuring political success. Policies for wellbeing must be built forward rather than be reactive to risks and they must be developed together with communities. The health impacts of new developments often cannot be assessed in the short term – that is why many policies that could protect health come too late, as the potential health impacts were not considered, communities were not involved or lobbying by industry was successful. We see this clearly in relation to the health impacts of digitalization (11).

While health promotion has been very committed to the inclusion of social science expertise from the

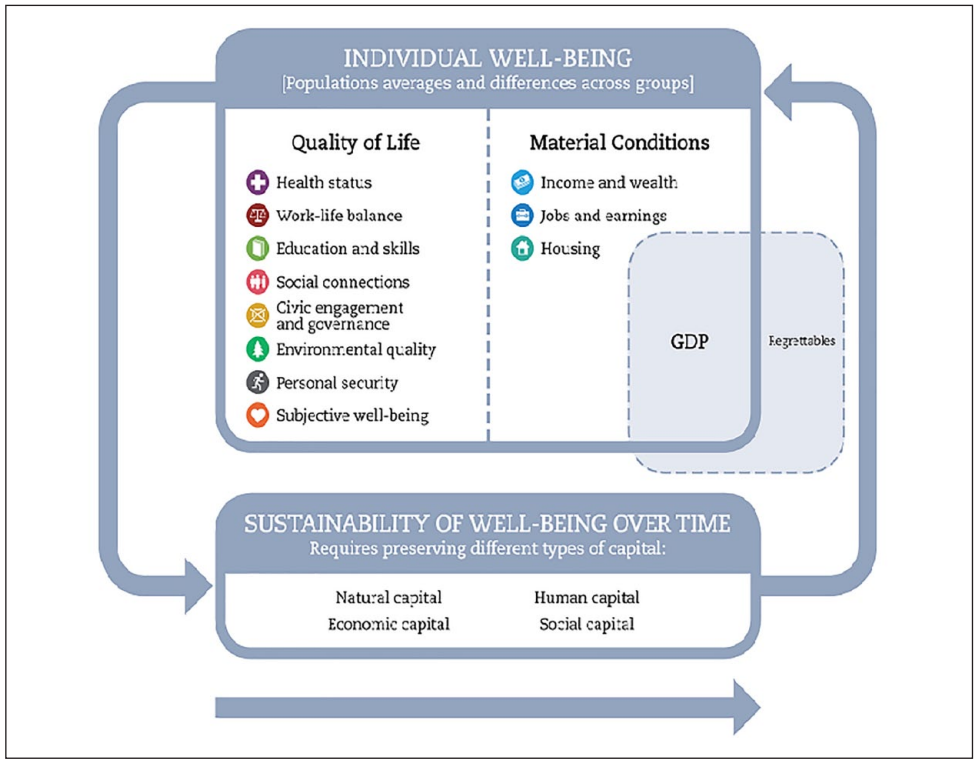

Figure 2. OECD framework for measuring wellbeing and progress.
Source: OECD (2013). https://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=SDD/DOC(2019)2&docLanguage=En

start, there is now a need for the use of complexity science to better understand the collective behaviour of social and economic organizations; increasingly, the term ecosystem is used to describe the many patterns of interactions between different players that emerge (12). The new data-driven approaches to gathering public health intelligence can help to engage in such new analytics. This also acknowledges that many of the challenges which health promotion aims to address are wicked problems. 'Wicked' means that they are very difficult or even impossible to resolve with simple solutions, not least because of the complex interdependencies and dynamics between influences (13). And finally, new problems need to be addressed, such as the impact of the digital transformation on our health and wellbeing – a dynamic not yet included in the original conceptualization of the social determinants of health (14).

The transformative metrics of wellbeing

Most people in the world do not live in safe and stable environments and do not benefit from economic development or the digital transformation. Health promotion must be one of the drivers to help create a better future – especially for the next generation. This is even more so as the COVID-19 pandemic and impacts of the climate crisis have reinforced existing inequalities, destroyed livelihoods, pushed people into poverty and increased many health problems (15). We must build forward better by focusing on transformation.

What do we define as success? All major international organizations agree that macro-economic data alone, such as GDP, do not provide a sufficiently detailed picture of the living conditions and the health and wellbeing that ordinary people experience (16). This applies to all countries at all levels of development, as the work of the World

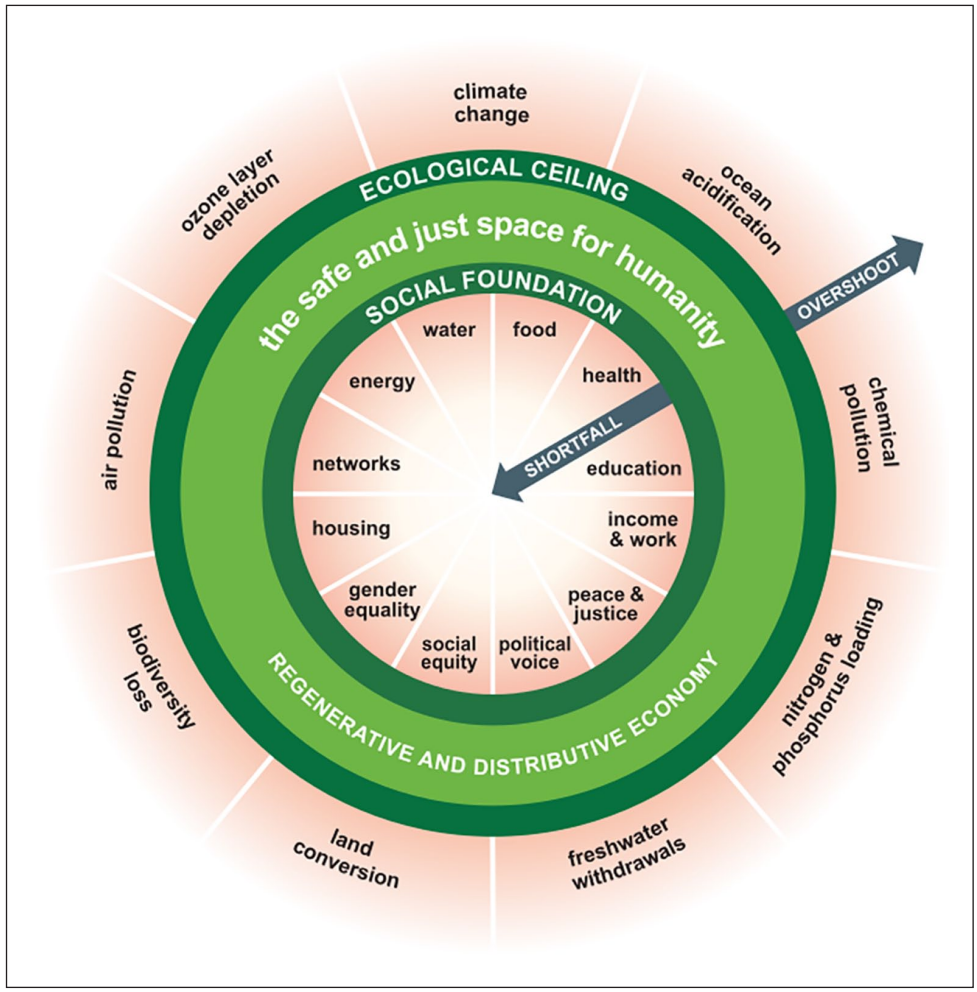

Figure 3. The doughnut of social and planetary boundaries.
Source: Doughnut Economics (2021). Available from: https://doughnuteconomics.org/about-doughnut-economics

Happiness Report (17) and of the Organisation for Economic Co-operation and Development (OECD) (18) on wellbeing has clearly shown. The measure we seek for health must be the health and wellbeing that people *experience in the context of everyday life*, where they live, love, work, play, shop, travel and google. These measures must also include environmental sustainability. The World Happiness Report 2020 for the first time ranks cities around the world by their subjective wellbeing and analyses how the social, urban and natural environments combine to affect our happiness (19).

Another step towards transforming the measures of a society's success is achieved by the metrics proposed by the OECD wellbeing index, which measures individual wellbeing through a combination of quality of life and material conditions and relates it to sustainability of wellbeing over time (20).

The OECD (2013) draws particular attention to the need to build and ensure four forms of capital over time: natural capital, economic capital, human capital and social capital. The World Bank also considers the investment in human capital as one of

the key strategies to ensure a better future. The OECD indicates visually in its graphs the very small part of wellbeing a measure such as GDP captures. The country comparisons that follow from this work are an excellent start for identifying the priorities of a national health promotion strategy with a focus on the determinants of health and wellbeing in all policies by incorporating these metrics and frameworks into a multidimensional policy decision-making approach for health and wellbeing. What they do not yet capture are dimensions of wellbeing that we have only recently begun to acknowledge – such as the impact of structural racism (21) or the level of violence against women (22). Health promotion must address the structures that shape people's aspirations and impact on their experienced wellbeing through social relationships over time.

Transformative action: the doughnut model

There are other new models that provide a solid base to move us forward. The 'doughnut model' relates the social foundations of our lives to the planetary boundaries. The economist Kate Raworth has developed a visual framework for sustainable development that allows us to capture both the access to life's essentials (healthcare, education, equity and so on) as well as the ecological ceilings that our life depends on (23). This model pictured below considers an economy as *prosperous* when 12 social foundations – what we in health promotion call the determinants of health – are met without overshooting any of the nine ecological ceilings. Based on this it is possible to identify the safe and just space for humanity supported by a regenerative and distributive economy. This approach addresses one of the gaps in the initial work on the social determinants of health – not yet having a full understanding of the interface between social and ecological challenges.

Just as the OECD wellbeing indicators are already being used by a number of countries, we can witness the 'doughnut' mindset already being applied by a number of cities. They can use a methodological guide for downscaling the doughnut to the city and turning it into a tool for transformative action. This could well be the next generation of 'healthy cities', an approach created by the health promotion movement, bringing together local aspirations with global responsibility (24).

Such approaches conduct governance through active co-design to make social, physical, commercial and digital environments conducive to health. They create new public spaces and platforms for empowerment, both in community settings and in the digital space. They develop governance that promotes health in many sectors and commits to equity, wellbeing, social participation and social inclusion (25).

Transformative design of 'supportive environments'

An integrated health promotion approach will focus on the patterns of economic, social and health risks that emerge for many people, over most of which they have no control. This now includes the digital environment of disinformation and data extraction (26). Health promotion must go to the next level by focusing on the interconnectedness and patterns between different policies, interventions and impacts. Most obvious are the combined impact of mobility, food systems, air pollution and inequity on both our health and the health of the planet (27). Health promotion must also apply the increased understanding of the strong interface between our minds and our bodies, between ourselves and the natural and built environments we live in. The COVID-19 lockdowns have made clear how dependent we are for our wellbeing on supportive social and physical environments and social interaction with others as well as with nature. Positive interaction with others improves our health status and our perceived wellbeing, as the growing research on loneliness or on cyberbullying shows. Feeling valued and feeling safe, having dignity and opportunity are key components of perceived wellbeing. Having access to green spaces improves our wellbeing (28).

Just as we design the physical environment, we can co-design our social environments to promote health and wellbeing. Obviously in a process that engages people to such an extent, such activities can become an integral part of behaviours and aspirations within the context of everyday lives – success comes with experienced wellbeing. Most significant is social contact – active rather than passive leisure activities build in socializing opportunities through health. A breakthrough

experience is the 'friendship bench', which encourages people to share problems and create a sense of belonging in communities (29).

While this kind of thinking has begun to be integrated into new approaches to city planning or the planning of schools, hospitals and offices, we are still far away from designing the digital environment to promote health and wellbeing. Here we find commercial strategies that not only are built to destroy the long-term social capital and trust our societies depend on, but also have direct health consequences such as addiction or a variety of other mental health problems. As health promotion addresses the commercial determinants of health (30) it must also turn to the commodification of attention through social media platforms (31). Health promotion must work with those that aim to make the internet be supportive of democratic social discourse, also for health. A concrete example is the development of 'civic tech' approaches to health in Taiwan, which shows that such approaches can both help fight a pandemic and strengthen democracy (32).

Data show that even where incomes increase, people's levels of wellbeing do not always follow unless economic empowerment matches social empowerment (33). Young people in particular are engaged in questioning long-standing models of growth which endanger both human and planetary health – and they are rightfully demanding a voice to engage in sustainable solutions. The recent 2019 United Nations Development Programme (UNDP) report 'Beyond income, beyond averages, beyond today' shows that new types of inequalities are opening up around technology and climate change, which in turn show significant impact on health and wellbeing (34).

Health promotion will therefore need to develop a much broader understanding of health literacy. It now needs to be approached in a way that combines health literacy, digital literacy and civic literacy. Increasingly it is also dependent on basic science literacy. Conversations on the web about health must be based on reliable information not fake news and infodemics (34), and they must be conducted in an environment of respect, just as many face-to-face community health activities are. The digital support and monitoring of health behaviour is expanding exponentially as apps on the phone, as watches that interface with vital signs, as diagnostic tools and mobile clinics. Health promotion must develop strategies that strengthen the positive impact of these new tools and technologies all around the world (35).

Reaping benefits from new approaches

We know that taking into account complexity is the hallmark of any successful policy (36) and an increasing number of countries have engaged in developing integrated policy by applying health in all policy, whole of government and whole of society approaches. Moving forward in such a direction will allow societies to reap significant benefit from policies that promote health, wellbeing and sustainability. Health promotion can take a leading role in this transformation towards health and wellbeing.

A new framework for health promotion must take its starting point from strategies that counteract the disempowerment many people feel. Societies and individuals are faced with 'wicked problems' and the increasing speed and complexity within which they need to be resolved. The COVID-19 pandemic has shown how difficult it is for some and how this can endanger democracy. The SDGs aim to respond to this complex world of change but for many people the speed of change is disorienting; they fear for their future and that of their children. The shaping of the future is not an expert exercise – it needs the kind of strong community involvement that health promotion has always advocated.

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ORCID iD

Ilona Kickbusch https://orcid.org/0000-0002-2699-7166

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Original Article

How can health promotion contribute to pulling humans back from the brink of disaster?

Fran Baum

Abstract: Health promotion has evolved over the last decades from a primary focus on behaviour change to establishing an ambitious goal of creating healthy, fair and sustainable environments in a manner which realises the rights of all people to health and well-being while protecting the health of our planet and its ecosystems. This paper argues that in order to contribute to this ambitious goal, health promotion must address three key tasks. The first is the need to take planetary health more seriously and move away from reductionist thinking to an approach that sees the planet as a complex system and values more harmony with nature, protects biodiversity and prevents global warming. The second task is to advocate and support governments to govern for health. The key to doing this is putting health and equity before profit, creating healthy urban environments, encouraging participatory decision-making, advocating for healthy economic models and assessing the ways in which corporate determinants of health operate. The third task is to ensure that moves to professionalise health promotion do not come at the expense of health promotion advocacy to powerful people and organisations. Health promotion is well placed to support civil society movements arguing for social and economic change that will benefit health such as the Black Lives Matter and environment movements.

Keywords: Climate change, determinants of health, empowerment/power, equity/social justice, health promotion, policy, politics, urban planning, urban health, urbanization

Introduction

> 'Climate change represents the greatest threat that humanity, as a whole, has ever had to manage. We are all involved, and we need to work together with urgency to generate the pathways to a safer world.' Sir David King, Chemist and Former UK Chief Scientist. (1)

In 2020, the human race is teetering on the edge of collapse in the face of massively growing inequities, which resulted from a neoliberal dominance in public policy, a warming planet that is projected to soon be unfit for human habitation, a pandemic, which in mid-2021 had claimed 3.87 million lives, and a fracturing of the fabric of trust, solidarity and caring so central to successful societies.

In the face of these crises and threats, what contribution is health promotion able to make? What reframing will be required to enable health promotion to exert the muscle power to pull us back from disaster to a safer world? In this article, I answer these questions by addressing what broadened goals of health promotion might look like and then ways in which health promotion can make a significant contribution to achieving these.

Central goals of health promotion

Health promotion's origins lay in the science of behaviourism and health education, which work

Southgate Institute for Health, Society and Equity, Flinders University, Adelaide, South Australia, Australia.

Correspondence to: Fran Baum, Southgate Institute for Health, Society and Equity, Flinders University, GPO Box 2100, Adelaide, South Australia 5001, Australia. Email: fran.baum@flinders.edu.au

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with individuals to educate them about and encourage them to adopt healthy lifestyles. Of course, this aim was worthy, but as trials were attempted, they didn't produce the promised results (2). Gradually, the realisation dawned on health promoters that individuals reflect the social, economic and physical environment in which they live. This realisation led to more sophisticated health promotion that worked with whole communities, regions or settings (schools, workplaces, hospitals) to consider how these environments could be made more supportive of health, such as the North Karelia experiment (3), which used policy to reduce cardiovascular risk.

Learning from the early days of health promotion, the next break through was reflected in the work of Nancy Milio who gave us the slogan of 'making healthy choices the easy choices'. Her work and that of other key health promoters such as Ilona Kickbusch, John Ashton and Trevor Hancock led to the groundbreaking WHO Ottawa Charter for Health Promotion (4). Its five strategies of health public policy, create supportive environments, strengthen community action, develop personal skills and reorient health services set the stage for health promotion to leave its behavioural roots behind and begin to look at the structures that support or constrain health. However, the Ottawa Charter largely remains an ideal, and much health promotion policy and practice within countries is still predominantly behavioural (5), despite the fact that the risks of climate change and economic inequities have increased.

Since the 1980s health promotion has focussed a little more on structures through the Healthy Cities, healthy schools, workplaces and prison initiatives. The WHO Commission on the Social Determinants of Health (6) emphasised that health required concerted action on the social determinants of health. More recently, planetary health (7) has and the commercial including corporate determinants (8,9) have also been highlighted. In addition, over the past decades health promotion has paid more attention to the equitable distribution of health. These developments mean that health promotion is a little better prepared to meet the ambitious goal of creating healthy, fair and sustainable environments in a manner which realises the rights of all people to health and well-being while protecting the health of our planet and its ecosystems. However, the urgency of the threat of global warming, the rapidly growing inequities and increasing threats from commercial determinants mean that the health promotion movement needs to embrace this urgency more fully and become part of a movement that works for systematic change including to the very value base of our societies. This will require a reframing of health promotion to enable it to make a more meaningful contribution to this systematic change.

Reframing health promotion in the rest of the 21st century

The reframing discussed in this section concerns the need to take planetary health more seriously; determining the role of health promotion in governing for health and health equity; and, finally, how to balance health promotion as a profession, with being a social movement.

Taking planetary health seriously

The prime importance of protecting the ecology of planet earth is now clear. Our ecosystems are threatened by human activity. There is now wide acceptance that our current era is the Anthropocene (10) because our activity is affecting earth's systems in irreversible ways. Scientists from around the world penned an open letter warning that the changes being brought by climate change and destruction of natural environments now threaten huge disruption and subsequent societal collapse (11). Chan (12), while Director General of the WHO, said 'Climate change is the defining health issue of the 21st century'. Health promotion then needs to determine how it will address this issue with more intensity than it does currently.

Globally, the International Union for Health Promotion and Education (IUHPE) has shown leadership in holding its last global conference on the topic of 'Promoting Planetary Health and Sustainable Development for All'. This conference provided a clarion call to the health promotion community to act and determine new actions to address our ecological crises.

Effectively addressing the threats of global warming resulting from the Anthropocene requires a dramatic change in societal values so that the drive to consume, exploit, compete, and dominate over others and nature is transformed to a society which

strives for equity between and within nations and accords the natural environment rights. A crucial way by which this can be done is by new conceptions of viewing humans in relation to nature. Latin American health promoters have started this conception through the movement *Buen Vivir*, which stresses the importance of communities rather than individuals, aims for ecological balance seeing humans as part of nature not separated from it and cultural sensitivity. This view draws on the cosmology of Indigenous peoples whose traditional lives have been in harmony with nature and making a much smaller ecological footprint on the planet than industrialised societies do. Our failure to respect nature has led to the alarming decline in biodiversity. A recent report from the UK Treasury on the economics of biodiversity (13) concludes that a deep-rooted, widespread institutional failure, which led to unsustainable engagement with nature, is endangering the prosperity of current and future generations. Health promoters can play an important role in advocating for a new set of values which protect nature and stress that any health promotion directed at humans will be wasted if the planet is no longer habitable for humans. Health promotion can influence planetary health globally (through organisations like IUHPE and the People's Health Movement), nationally through health promotion associations and locally through monitoring local environments and pointing out impacts on human health of environment degradation and synergistic impacts and by advocating for change.

In the past, health promotion has sought credibility with medicine by adopting reductionist approaches, which have focused on simple models of causation and built interventions based on such understandings. Thus, cardiovascular disease was seen to result from lack of exercise and poor diet and smoking, and so education was provided to bring about lifestyle change. The problem with such approaches is that they do not take account of people's life circumstances. Yet, people's choices are constrained by their circumstances including the jobs they do, their income and the extent to which their life is stressful. This information has been known for some time through studies, which in the 1950s (14) showed that bus drivers had higher rates of cardiovascular disease than conductors who were more physically active. Evidence has accumulated since then to show the power of broad determinants on health (6). This includes viewing lifestyle choices as being very largely shaped by social, economic, commercial and political determinants. While these factors have been recognised in the series of WHO conferences on health promotion, it is rare for an understanding of broader determinants to drive national and local health promotion activity.

The United Nations 2015 Sustainable Development Goals (SDGs) called for society-wide and cross-sector activity. Thus, they are an important touchstone for health promotion. Yet, health promotion must also critique their limitations and do so in three areas. These relate to the SDGs' uncritical acceptance of the dominant neoliberal model (15). This economic model encourages capital to exploit natural resources, including fossil fuels, by advocating small government and reducing the state's regulatory capacity. The dominant neoliberal economic model is based on the assumption of unlimited growth and does not account for the fact that our planet is a closed system. Secondly, the SDGs present poverty as a problem rather than a result of increasing wealth inequality. Thirdly, the SDGs do not challenge the consumerism that contributes to environmental degradation. Health promotion associations and activists should call for a revision to the SDGs so that they do challenge the dominant economic model and call instead for one that gives primacy to human and ecological health and challenges unsustainable global consumption and an unsustainable growth in population (7).

Health promotion can also play a role in joining up dots between the different crises affecting the world. Planetary health has an impact across our systems and interacts with other threats. Our current pandemic is a result of the spread of a zoonotic corona virus (16). It has long been pointed out (17) that continuing to destroy delicately balanced ecosystems creates a much greater chance that virus will cross species as they have been doing in recent years. Another example of how planetary health issues interact with others is that the mental health impacts of Covid-19 in Australia were found across the entire population, but for those affected by bushfires the impact was much worse (18). A further example is that Covid-19 deaths in areas with high air pollution have been found to be higher (19). Health promoters are well-placed to detect these patterns affecting human health and to draw attention to them and work to reduce their impacts.

Determining what governing for health and health equity might look like

If we are to survive and maintain healthy and sustainable lives, then current patterns of governance will need to change. The Ottawa Charter set out the challenge for health promotion to be concerned with healthy public policy in all sectors. Yet, it is rare for a national or regional health promotion response to enact all the five strategies of the Ottawa Charter. It is more common for there to be action on settings and behaviours and very often without attention to equity considerations or addressing power imbalances (20). In addition, commentators have noted what has been described as a 'lifestyle drift' whereby policy makers may start with a recognition of the upstream determinants of health but then drift downstream to strategies that focus on individual behaviour change (21,22). In sum, this means that health promotion needs to determine the structural issues that require action in order to govern for health and equity (23).

Health and equity before profits

Governing for health is first and foremost about putting consideration of health and equity impacts above those of profit motives. Of course, there are arguments that profit-making activity can promote health such as through the provision of jobs. But health promotion can determine if the jobs provided could be made healthier such as ensuring occupational health issues such as eye safety (24) and working with trade unions on issues of work conditions, such as gig employment and casualised work (25,26).

A feature of neoliberalism has been the rapid growth of economic inequities, which will, over time, create health inequities. While life expectancy has continued to grow in Australia, the distribution of health has grown more unequal (27,28), the health inequalities ratio for deaths for avoidable causes in Australia has increased from 1.55 to 2.06 between 1997–2001 and 2010–2015 (27). Over a similar period, economic inequality in Australia has also increased significantly (29). Such patterns are common in many countries. An equity perspective should permeate all health promotion activity. Box 1 shows how VicHealth, Australia (a statutory health promotion agency) has responded rapidly to put an equity lens over Covid-19.

The Covid-19 pandemic has affected groups differentially and will almost certainly increase inequities (25). The pandemic has also underlined the absence of global solidarity as rich countries have not ensured vaccines are distributed equitably despite calls from WHO (26). Many health promotion issues require globally co-ordinated responses, yet these are rare. None of the WHO health promotion charters and declarations have addressed the commercial determinants of health (9) in any way that recognised the growing power and influence of transnational corporations (TNCs) despite the recognition that they are profoundly affecting our health (30). A corporate health impact assessment instrument has been developed and applied to a fast food chain and a mining company (31,32). This instrument identifies health-harming practices resulting from corporate practices such as tax evasion or the product such as cigarette or high fat and sugar foods. This body of work is important to health promotion because it identified the ways in which people's lifestyles are shaped by the action of large corporations. It can thus guide local health promotion action so that a health promoter might support community actions against new fast food outlets or question the advertising practices of alcohol companies, for example. It also emphasises the need for concerted global action to control the health-harming practices of TNCs.

Box 1. VicHealth's equity response to Covid-19

VicHealth is a health promotion foundation funded by the Victorian government, through a tax on tobacco. Since its formation, it has worked to address barriers to physical and mental well-being faced by Victorians, embedding an equity approach in every aspect of its work. Throughout the pandemic and its aftermath in Victoria, VicHealth demonstrated its foundational focus on equity by advocating for those who were indirectly hit hardest by the pandemic. A survey conducted by the organisation during the pandemic, demonstrated alarming rates of food insecurity, mental distress and physical inactivity among Victorians, especially for young people. In response they reframed key initiatives to enable a swift response. For example the *This Girl Can* campaign was adapted to help keep women and

Box 1. (Continued)

girls active during lockdown. They also boosted their support to organisations that provide immediate food relief. Following the first 2020 lockdown, VicHealth provided $3.9m of funding to 460 locally-led and community-owned initiatives through the Reimagining Health grant round, that addresses key areas of concern including food security, social connection and physical activity. Organisations that received funding include *United Through Football*, which runs sporting programs for children and young people living in public housing. Victorians living in regional areas were also supported, for example, Bendigo Foodshare which educates young people about growing their own food and cooking, so opening pathways to employment in the food sector. VicHealth is also advocating for an equitable recovery that builds back better and fairer for all.

Source: VicHealth (33)

Inequities are also reflected in the unequal impacts of climate change. Margaret Chan (12) (Director General Emeritus of the WHO) has noted that low- and middle-income countries will suffer most and '...those that have contributed least to the problem and are least prepared to cope with its consequences'.

A further aspect of inequities concerns the strong adverse impact racism has on health (34). Around the world Indigenous and Black people have worse health status than non-Black and non-Indigenous populations (35). This was highlighted by the Covid-19 death rates, which were higher in these groups. For example, the US high death rate among African Americans has meant that the life expectancy of this group has fallen by 2.7 years (36). In Brazil, Amazon Indigenous populations have also suffered particularly high Covid-19 death rates (37). Indigenous and Black communities are not vulnerable in themselves; they have been made so by the legacy and persistence of colonial practices. Anger at this legacy in the US police force sparked a global civil society protest under the slogan Black Lives Matter. Health promoters can lend greater support to this movement as well as to the broader project of decolonisation by restoring self-determination to Indigenous and Black populations.

Healthy urban environments

Governing for health requires the creation of healthy urban environments and the WHO Healthy Cities movement (38–40) has played a major role in working towards that goal through bringing health into the decision-making, policies and practices of local government. An example is the work done to promote healthy urban planning (38). A further institutional mechanism to promote health is the Health in All Policies (HiAP) (41) initiative, which is being adopted in a growing number of jurisdictions. However, there is no evidence that HiAP addresses inequities and some that this does not happen (42). The crucial point about such initiatives is that they are focused on environments and how they can be changed to support people's health. By doing this they avoid victim blaming (43) and reliance on behaviourism by addressing more wide-reaching structural changes that drive patterns of behaviour (5). If Healthy Cities and HiAP were implemented more widely with a strong equity agenda then health promotion would be better placed to tackle the upstream determinants of health.

Participatory decision-making

Health promoters can also play a role in arguing for participation in decision-making in policy processes and organisations. Public policy is more likely to be health promoting and equitable if citizens are involved in designing policy. Citizens offer a balance to the influence of those with vested interests. There are many means of including a citizen's voice in decisions including citizen juries, co-design processes, formal consultation processes and community membership on governing boards (2).

Health-promoting economics

Health promotion has learnt the importance of action in all sectors but very often those that partner with health promotion are the 'soft' sectors like education and social services. Yet there is also much to be gained by influencing the policy in the sectors which hold most power in governments. Prime among these are finance departments and treasuries. While grassroots health promoters will have little influence, health promotion associations are able to lobby for health to be much more prominent in

governments' financial decisions. The past few years has seen several governments adopt well-being budgets, which move away from a sole focus on Gross Domestic Product as a measure of progress and move to include other measures such as population mental health. The New Zealand well-being budget (44), for example, includes the follow priorities, which will all contribute to improved health and some (2,3) to inequities:

1. improving mental health (including an emphasis on primary prevention of mental illness);
2. reducing child poverty;
3. addressing the inequalities faced by indigenous Māori and Pacific Island people;
4. thriving in a digital age; and
5. transitioning to a low-emission, sustainable economy.

Health promoters should be advocating for well-being budgets everywhere as this perspective will likely mean more funding for health promotion activities and policies that promote health and well-being. The voices of health promoters are often disregarded in debates about the allocation of government budgets. The emergence of well-being budgets may see health promoters voices taken more seriously.

Well-being budgets are supported by economists and others who argue against the domination of neoliberal economics in public decision-making. Examples are Kelton's (45) Modern Monetary Theory, Raworth's (46) Doughnut Economics and Daly's (47) Steady State Economics. Health promoters could do well to understand these arguments and be confident in presenting them as they support advocacy for health promoting policy and practice and support the importance of spending on prevention and promotion.

Profession and/or social movement?

In recent years, health promotion has moved to gain formal accreditation for its practitioners. IUHPE has developed an international accreditation scheme for the profession. IUHPE's (48) core competencies and professional standards are based on the Ottawa Charter and stress competencies that would be required to contribute to the issues raised above, including bringing about healthy change, advocacy, making effective partnerships and working for health equity. Such an accreditation scheme is vital for health promoters when so often they are disregarded under the institutional power of medicine. Despite this, the professionalisation of health promotion does pose some questions for the ways in which health promoters work. Supporting an ecologically sustainable world is going to require considerable change, which will be opposed by powerful interests. Health promoters then face ethical questions about how far they are prepared to go (in the name of improved ecological and human health and equity) in questioning practices that are not compatible with a healthy future. They will have to be prepared to challenge the practices of the organisations that they work in and public policies that are not compatible with creating such a future. Health promoters will have to ask themselves if they are prepared to rock the status quo boat in the interest of health and equity. Or will they be looking nervously over their shoulder to ensure they don't upset more powerful people to protect their careers. Health promoters will need to be prepared to speak truth to power, especially when those holding power do not want to hear the messages. These are common dilemmas but are more evident for health promoters whose concern, more than any other profession, is with creating a healthier, sustainable and more equal future.

National advocacy can be done through professional associations and civil society. I have been active with the Global People's Health Movement (PHM) since it was formed in 2000. This network brings together health activists from around the world. The PHM People's Health Charter notes in its preamble:

> Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for all means that powerful interests have to be challenged, that globalisation has to be opposed, and that political and economic priorities have to be drastically changed. This Charter builds on perspectives of people whose voices have rarely been heard before, if at all. It encourages people to develop their own solutions and to hold accountable local authorities, national governments, international organisations and corporations. (49)

Such social movements are powerful agents for change. Indeed, it is hard to think of a healthy social change which hasn't been spearheaded initially by a social movement. Take, for example, the following movements: women's liberation and the Suffragettes, anti-slavery, pro-gay marriage, the US civil rights and the #MeToo movement. Each involved people opposing an existing unhealthy situation and then working steadily to ensure a health promoting change was brought about. Change is achieved when those holding political power are forced by those advocating for change to find the political will to take action that challenges established power bases. Achieving real change will require health promoters to navigate structural power inequities in order to disrupt the status quo and advance a comprehensive policy agenda on the social determinants of health equity (50). Doing this requires a sophisticated understanding of how power works and what processes can undermine it. Social movements are often skilled at this and are working on a great range of issues relevant to health including climate change, LGBTQi rights, refugee rights, Indigenous peoples rights, housing and ecological protection. These movements are natural allies of health promoters and working together more effectively will increase likelihood of power holders and their preferred status quo being challenged.

It is also important to acknowledge that many people do health promotion as part of their job even though it is not their central role. Thus, doctors and nurses can work with their patients to assist them adopting healthy lifestyles, urban planners can take health consideration into account in their plans, teachers can promote health as they educate, economists can promote models which prioritise health and community development workers in many settings contribute to community health. Promoting health is a whole-of-society task and we must be careful that professionalising the role still leaves plenty of room for others to see themselves as health promoters.

Conclusion

In 1995 and 2010 David Sanders and I wrote articles calling for health promotion to return to a more radical agenda (20,51). The same call needs to be made today. The difference now is that the stakes are higher. We need a whole-of-society rethink about how we have neglected the stewardship of our beautiful planet and allowed a mindset dominated by a narrow economic focus to drive our public policy and create evergrowing inequities and allowed the creation of unhealthy corporations. Health promoters need to become troublemakers for health and play our part in disrupting the current unhealthy ecological and economic systems which are likely to lead to global catastrophe. Our goal is for a healthy, equitable and sustainable planet in which all humans can flourish, and we have to be prepared to engage in a struggle to realise that goal.

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ORCID iD

Fran Baum https://orcid.org/0000-0002-2294-1368

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Waiora: the importance of Indigenous worldviews and spirituality to inspire and inform Planetary Health Promotion in the Anthropocene

Sione Tu'itahi[1], Huti Watson[2], Richard Egan[3], Margot W. Parkes[4] and Trevor Hancock[5]

Abstract: We now live in a new geological age, the Anthropocene – the age of humans – the start of which coincides with the founding of the International Union for Health Promotion and Education (IUHPE) 70 years ago. In this article, we address the fundamental challenge facing health promotion in its next 70 years, which takes us almost to 2100: how do we achieve planetary health? We begin with a brief overview of the massive and rapid global ecological changes we face, the social, economic and technological driving forces behind those changes, and their health implications. At the heart of these driving forces lie a set of core values that are incompatible with planetary health. Central to our argument is the need for a new set of values, which heed and privilege the wisdom of Indigenous worldviews, as well as a renewed sense of spirituality that can re-establish a reverence for nature. We propose an Indigenous-informed framing to inspire and inform what we call planetary health promotion so that, as the United Nations Secretary General wrote recently, we can make peace with nature.

Keywords: Planetary health, spirituality, Anthropocene, healthy cities/healthy communities, Indigenous worldviews, core values, Indigenous knowledge

Introduction

> 'The conference participants call on the global community to urgently act to promote planetary health and sustainable development for all, now and for the sake of future generations.'
>
> Rotorua Statement – IUHPE 2019 (1)

'Waiora is an Indigenous concept of ... Aotearoa New Zealand which expresses the interconnections between peoples' health and the natural environment, and the imperative of sustainable development' (1). It lies at the heart of the new era of health promotion that we must create if we are to ensure health for all by the year 2100.[1]

We now live in the Anthropocene, the age of humans (*anthropos* being the Ancient Greek word for humans), a new geologic epoch in which the strata now being deposited record the massive and rapid global ecological changes brought on by humanity (2). Note that this new age – for which the suggested start date coincides with the founding of IUHPE 70 years ago – is not about humanity, but is

1. Health Promotion Forum of New Zealand/Runanga Whakapiki Ake i te Hauora o Aotearoa (HPF), New Zealand.
2. Ngati Porou Hauora Trust, Te Puia Springs, New Zealand.
3. Department of Preventive and Social Medicine/Te Tari Hauora Tūmatanui, Dunedin School of Medicine/Te Kura Hauora O Ōtepoti, University of Otago/Te Whare Wānanga O Otago, Dunedin, New Zealand.
4. School of Health Sciences, University of Northern British Columbia, Prince George, British Columbia, Canada.
5. School of Public Health and Social Policy, University of Victoria, Victoria, British Columbia, Canada.

Correspondence to: Trevor Hancock, School of Public Health and Social Policy, University of Victoria, 494 Ker Ave, Victoria, BC V9A 2B7, Canada. Email: Thancock@uvic.ca

The authors are all members of the IUHPE Global Working Group on Waiora Planetary Health and Human Wellbeing

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due to the actions of humanity – the social, economic and technological driving forces we have created that are changing the Earth's natural systems.

At the heart of these driving forces lie a set of core values – rooted in Judaeo-Christian thought (3), the Enlightenment and Modernity (4) – that are incompatible with planetary health, which is: 'The health of human civilisation and the state of the natural systems on which it depends (5, p. 1973)'.

This article addresses the fundamental challenge facing health promotion in its next 70 years, which takes us almost to 2100: how do we help to change the current unsustainable trajectory for humanity, a trajectory that threatens the stability of our societies and the health not only of humanity but also of myriad other species with whom we share the Earth?

Our contribution is co-authored by a collaborative group of Indigenous and non-Indigenous health promoters from varied positions who seek collectively to elevate and centre Indigenous world views and voices as critical to the future of a healthy planet. As a collective, we acknowledge the oppression, marginalisation and exploitation suffered by Indigenous peoples, the desecration of their cultural and traditional landscapes, and the erosion of their rights to be sovereign in their respective nations (6). We speak to non-Indigenous health promotion communities to engage in a process of critical self-reflection so that together we may become better equipped to appropriately welcome and respect, believe and validate, centre and value Indigenous knowledges and contexts (7). Furthermore, in keeping with the challenge of the United Nations (UN) Declaration on the Rights of Indigenous Peoples (8), we support the reclamation, restoration and celebration of Indigenous culture, identity and belonging and advocate that these principles must underpin the future of health promotion.

We argue that health promotion can offer an example of leadership by promoting values that privilege the long-standing wisdom of Indigenous worldviews and re-establish a reverence for nature. As the UN Secretary General recently stated with respect to Indigenous people in the context of the growing ecological crises, 'it is time to heed their voices, reward their knowledge and respect their rights (9)', adding later that the challenge to 'Make peace with Nature' must also align with respect for Indigenous peoples (10). These challenges inform our article's focus, learning from Indigenous knowledges and spirituality to inform and inspire what we call planetary health promotion.

Welcome to the Anthropocene

It is not within the scope of this paper to describe the full extent of the global ecological changes we face, the human driving forces behind them or their health implications; we recognise that these phenomena are inextricably linked with the colonisation of other countries by British and European powers in the 15th and 16th centuries, the rise of capitalism in its wake with its voracious appetite for the Earth's resources, the subsequent dispossession of Indigenous peoples from their lands, the loss of relationship with their traditional landscapes and their ongoing suffering as a result of colonial oppression (11–14).

The accompanying Supplementary File 2 offers unfamiliar readers a description of key transformations seen in recent years and the changes we must expect in coming years if we do not profoundly change how we humans interact with nature.

In more recent years – just over two generations[b] – humanity as a whole (but in fact, mainly people in high-income industrialised countries) has created a 'great acceleration' in human, social and technological development, while at the same time creating a 'great decline' in the capacity and functioning of many Earth systems (15).

Humans have become a force of nature that has started to undermine and unbalance the Earth's natural systems. Since these natural systems constitute the most fundamental ecological determinants of health (16), undermining them is a profound threat to health; climate change tipping point cascades alone may pose 'an existential threat to civilization (17)'.

So, while there has been a significant improvement in many aspects of health and wellbeing for many people since 1950, and this is expected to continue, it has come at a huge and unsustainable cost in ecological degradation, which has profound implications for health in the future. As the Rockefeller-Lancet Commission on Planetary Health put it:

> 'we have been mortgaging the health of future generations to realise economic and development gains in the present (5, p. 1973)'.

Looking 70 years ahead takes us forward just over two generations to 2091, which is within the global average life expectancy at birth in 2018 of 72.4 years (18), meaning many infants born today will still be alive then. But it is difficult, if not impossible, to predict where we will be in another 70 years. To get some sense of the challenge, try to imagine predicting, in 1950, the Internet, Google and Twitter; the extent of climate change, microplastic pollution of the ocean and species extinction in 2020; or the rejection of smoking and the acceptance of gay marriage in many parts of the world. Many of these were then in the realm of science fiction!

Nonetheless, we can be reasonably sure that population growth will continue at least until 2050, and probably until 2100, as will urbanisation and economic development. As a result, states the United Nations Environment Programme (UNEP)'s GEO-6 Environmental Outlook, 'the demand for food, water and energy will strongly increase towards 2050 (19, p.486)'.

GEO-6 finds that for 9 of the 10 natural resource base areas of concern, not only will the target for improvement by 2050 not be met, but the trend is in the wrong direction and the situation is actually expected to be worse – often, far worse – than the situation in 2020. This will have profound implications for health; if ecosystems decline or collapse, all bets about the future health of the population are off!

The implications of the Anthropocene are now attracting the attention of global leaders at the highest level. Most notably Antonio Guterres, Secretary General of the UN, has stated 'Humanity is waging war on nature. This is senseless and suicidal... Making peace with nature is the defining task of the coming decades (10, p.4)'.

As Mother Earth is the sustainer of all life, the health sector and health promotion are therefore obliged to seek solutions to address these concerns. In responding to this call, we call attention to Indigenous voices and spirituality as critical to next-generation health promotion practices.

Indigenous peoples' voices and knowledge in planetary health

> *'We call on the health promotion community and the wider global community to make space for and privilege Indigenous peoples' voices and Indigenous knowledges in taking action with us to promote the health of Mother Earth and sustainable development for the benefit of all'*
>
> Waiora – Indigenous Peoples' Statement, *IUHPE 2019* (20)

The global challenges noted above have raised greater awareness across the world of the inherent interdependence of all forms of life, and the planet as one system. But this reality is not new to the 476 million Indigenous peoples of the world (21). In fact, viewing humanity as deeply connected with the environment is a central element of Indigenous knowledge systems. This is aptly demonstrated in the Pacific Indigenous concept of whenua or fonua (22).

In Te Reo Māori, the language of the Indigenous peoples of Aotearoa New Zealand, whenua means the land and people are one. As Durie noted, 'Although there is no simple definition of Indigenous peoples, two important characteristics are an ancient relationship with some geographical place and an ethnic distinctiveness from others now living alongside them (23)'.

So central is this concept of being one with the environment in many other Pacific Indigenous cultures, such as Tonga, that the placenta, the physical plane, the grave and the world hereafter are all called the fonua, the Tongan cognate for whenua (22). Fonua reflects a profound understanding of the planet as a web of life, a complex system of unity in diversity, where all elements are connected coherently in a dynamic relationship for its harmonious and holistic wellbeing. The part is the whole, the whole is the part.

The two Legacy Statements of the 2019 IUHPE World Conference on Health Promotion echo this understanding, with the Waiora Indigenous Peoples' Statement (20) observing:

> *'Core features of Indigenous worldviews are the interactive relationship between spiritual and material realms, intergenerational and collective orientations, that Mother Earth is a living being – a "person" with whom we have special relationships that are a foundation for identity, and the interconnectedness and interdependence between all that exists, which locates humanity as*

part of Mother Earth's ecosystems alongside our relations in the natural world'.

Meanwhile, its sister statement, the Rotorua Statement (1) noted that planetary health

'builds on Indigenous peoples' principles of holism and interconnectedness, strengthening public health and health promotion action on ecological and social determinants of health. It puts the wellbeing of people and the planet at the heart of decision-making'.

After centuries of colonisation and oppression, Indigenous Peoples and their knowledge are recognised as valuable contributors to the future of humanity and the global challenges it is now facing. The UN Department of Social and Economic Development Affairs (24) acknowledges 'the crucial role of Indigenous knowledge for achieving the Sustainable Development Goals (SDGs) and for addressing the most pressing global problems' is gaining international traction. Additionally, Indigenous knowledge also 'offers tremendous opportunities in such areas as land management, conservation, and scientific, technological and medical research'. UN Secretary General Antonio Guterres (9) noted:

'...Indigenous knowledge, distilled over millennia of close and direct contact with nature, can help to point the way. Indigenous peoples make up less than 6 per cent of the world's population yet are stewards of 80 per cent of the world's biodiversity on land. Already, we know that nature managed by indigenous peoples is declining less rapidly than elsewhere. With indigenous peoples living on land that is among the most vulnerable to climate change and environmental degradation, it is time to heed their voices, reward their knowledge and respect their rights'.

Referring to our collective effort to counter coronavirus disease 2019 (COVID-19), Guterres (9) also pointed out that, 'in overcoming the pandemic, we can also avert climate cataclysm and restore our planet. This is an epic policy test. But ultimately this is a moral test'. Indigenous knowledge offers myriad lessons for this moral test, especially spiritual dimensions (as discussed below), and also underscores the benefits of disturbing harmful patterns across numerous domains (11–14,23–25).

A practical example of how Indigenous knowledge can evolve into a sociopolitical tool to improve environmental concerns is evidenced by the Māori concept of Kaitiakitanga, (understood broadly as guardianship or custodianship). Kaitiakitanga is a cultural framework and ethic that enables Māori oversight of conservation and environmental concerns in partnership with local government and other organisations in relation to the Resource Management Act of New Zealand, and is a means for transforming Māori involvement and expression in new political and legal contexts (26). Formalised and equal relationships between Indigenous groups and others to address these common concerns may be a way forward.

As noted in the Rotorua Statement, much of the ecological devastation caused by unsustainable economic development across the world is founded on the erroneous human construct that humans are separate from the environment, which is seen as an unlimited resource to be exploited. This is the opposite of the Indigenous wisdom that there is an inseparable interaction and contiguity between humanity and the natural environment (14, 27).

The part cannot undermine the whole upon which it depends, and of which it is a part. Indigenous health promotion models (22, 23) show that, as custodians, humans should not only live sustainably within the environment, but must also adopt a collaborative and equitable approach in their relationship with fellow human beings. This is why fundamental, guiding principles such as reciprocity, love, respect, humility and justice are pivotal to the worldview and daily, practical living of Indigenous peoples.

A key task for health promotion in the 21st century is to create spaces where Indigenous Peoples can be recognized as leaders, inspiring and informing ways to incorporate these values, principles and ways of knowing into health promotion practice. As exemplified by the examples here, Indigenous leadership is offering new opportunities for the health community to fulfil its obligations to the future (28, 29).

The place of spirituality in planetary health

Spirituality is another facet of human life that offers pathways to re-engage with humanity's deep connection with the natural world (30) and to foster environmental awareness, activism and wellbeing in ways that can enhance both health promotion and planetary health. Due to growing evidence and principle-based approaches (31, 32), spirituality is increasingly evident in health and wellbeing models and health policy across the globe (33). While contentious issues regarding definitions remain (34), religion in current health scholarship may be understood as a subset of spirituality, with more focussed institutional and belief structures. Spirituality definitions are multifactorial and vary between individuals and groups, but include beliefs and values, meaning and purpose, identity, connectedness, awareness and transcendence (35). The Bangkok Charter (36) included spirituality explicitly in its health promotion definition, as do many wellbeing definitions such as the hospice framework (37) and Indigenous models (22, 23). From an Indigenous perspective, spirituality is central to holistic wellbeing. As noted earlier, the 2019 Waiora Indigenous Legacy Statement recognized 'Core features of Indigenous worldviews are the interactive relationship between spiritual and material realms ...'; and that 'Mother Earth is a living being (20)'.

While acknowledging the growth of 'nones/non-affiliated' and the 'spiritual but not religious' (38), in the post-secular world, over 80% of the global population is actively religious (39). Therefore, those with religious spiritualties need to be able to connect their beliefs with the ethical and moral issues of the global ecological crisis, and become active protagonists in naming the spiritualities that can underpin future policies and practice.

The ecological crisis of the Anthropocene is unequivocally humanly induced, but humanity's inter- relationship with nature has not always been dysfunctional. In keeping with Indigenous worldviews, and often counter to the disconnection created by colonial norms, experiences of the natural world continue to inspire spiritual wellbeing (40), spiritually related positive effect (41) and eudaimonic wellbeing (42).[c] Many religious traditions have acknowledged and harnessed this spiritual connection with the Earth – from hunter-gatherers' worship of nature, to the Indigenous personification of land and sky (43) and formal religions' recognition of the sacredness of the land (44).

Widespread spiritual aridity or void (45, 46) and 'despiritualisation (47, p. 28)' may have led us to this crisis, and dominant Anthropocene values and spiritualities may have compounded the problem that has led us to such exploitation of the planet. For example, the Christian domination discourse from Genesis 1:26–28, suggests that humans have dominion over the Earth, the planet and animals, which has resulted in justification for exploitation (48). Bioreductionism, scientific reductionism, extreme materialism and neoliberal economics have all contributed to 'life-denying and life harming' activities (47, p.28) and led to a 'dysfunctional relationship with the natural environment (40, p.408)', facilitating the exploitation and commodification of the natural world. These activities are not sustainable, nor are they equitable. Exploitation and commodification of spiritualities (49) need to be considered in these analyses – but in contrast to the dysfunctional spiritualities of neoliberal economics, an eco-spiritual lens will highlight their impaired vision for sustainable living.

Seldom in mainstream health promotion and planetary health action do we work with Indigenous peoples' spiritualities and institutions that can work to empower communities and contribute to advancing the health and wellbeing of all, including the health of the environment (23). Proactively highlighting eco-spiritual approaches has the potential to affect fundamental values and behaviour.

Similarly, it is important to acknowledge current environmental movements within faith-based organisations, where the dominion narrative is reinterpreted as a 'stewardship or creation care', one that highlights justice, duty and responsibility towards both the Earth and future generations (48, p.591). Pope Francis' encyclical Laudato Si 'critiques consumerism and irresponsible development, laments environmental degradation and global warming (50, p.51)', calling for unified and global action. Similarly, Berry, in Egri (40), calls for a new story of transformational change challenging the dominion narrative, instead offering a stewardship approach (48) that has some similarities to the kaitiakitanga or guardianship approach expressed by Māori long before Berry (26).

The Bahá'í Scriptures articulate a conceptual framework that describes nature as a 'reflection of the sacred' that should be valued and respected. It further proposes an approach that includes a deep understanding of the natural world and its role in humanity's collective material and spiritual development (51). This reflection of the sacred resonates with ancient Indigenous concepts of people as trustees, or stewards of the planet's resources and biological diversity, and their responsibility to preserve and sustain the natural order of the environment.

> '*Therefore, sustainable environmental management must come to be seen not as a discretionary commitment mankind can weigh against other competing interests, but rather as a fundamental responsibility that must be shouldered – a prerequisite for spiritual development as well as the individual's physical survival* (51).'

We know from the health literature that spirituality is important to health outcomes (32). Similarly, pluralistic and inclusive spirituality is expressed by many people across the globe (44). To enhance 'Earth stewardship', noting human wellbeing 'depends on nature', Chapin *et al*. (52) suggest encouraging a 'sense of place', while including the 'spiritual dimensions of ecosystems (p. 90)' is something that health promoters could make part of their planetary health lens. The call to 'reduce unnecessary consumption' and promote 'environmental citizenship (52, p. 90)' fits appropriately into a planetary health approach. The spiritual impulse, one that demands consideration and investigation of our values and beliefs, our worldviews – calls for an integrative holistic and compassionate spirituality – challenging the foundations of selfish political and economic power that creates human and planetary harms (53).

A pro-spiritual lens will draw on many of the values that health promotion espouses, such as interdependence, equity, love and kindness (54), that offer hope for a sustainable planet. Gerhardt-Strachan highlights the lack of spiritual discourse in health promotion, calling for its inclusion 'for effective human and planetary wellbeing (55, p. 1)'. We need to take this seriously and make spiritualities explicit and ecologically responsible in the new planetary health promotion framework.

People, place and planet: toward a new era of planetary health promotion

Health promotion is action-oriented: as a concept, a field and a form of practice, it invokes action (to 'promote' health). Recognising the human-created degradation of the living systems and planet we depend on, a central challenge for all health promoters – and all who aspire to promote health – in the 21st century is to identify and prioritise health promotion actions that align with the imperatives of Indigenous and spiritual perspectives identified in earlier sections of this paper. The converging crises of climate change, biodiversity loss and pollution (10) call for a new era of practices that focus on regeneration, reciprocity and care in ways that span people, place and planet (56).

Importantly, in keeping with the wisdoms of Indigenous perspectives, and the dynamic, and expanding efforts underway in Indigenous Health Promotion (22,23,28), this new era is not 'all new', and can be invigorated by re-calling and weaving together ideas and approaches from past and present that better serve our current and future context, including individual and collective spiritualities. A foundational health promotion idea deserving reinvigoration to guide future planetary health promotion practice is the idea of 'reciprocal maintenance' from the Ottawa Charter; the need to 'take care of each other, our communities and our natural environment (57)'.

Put simply: health promotion practice has the opportunity to be transformational if reoriented to all three of these at once: taking care of each other (people), our communities (within place) and our natural environment (planet). Mutual reciprocity fuels the creative co-benefits of both/and/all rather than the diminishment of either/or approaches.

Health promotion practices that focus solely on the 'social' (equity, diversity, inclusion, etc.), while waiting for others to deal with the 'ecological' (the environment and living systems we depend on) – or vice versa – are no longer sufficient if the goal is to promote health for both current and future generations. Health promotion practices that focus explicitly on both the social ('each other, our communities') and the ecological ('our natural

environment') have the potential to fulfil the socio-ecological promise of the Ottawa Charter.

Leveraging on existing strengths and processes, health promotion has the potential to provide leadership and vision for an overdue era of overtly eco-social approaches to public health (58,59) that overcome long-standing ecological blindness (60–62) and orient to intergenerational and indeed inter-species equity (56). This orientation realigns with the wisdom of Indigenous practices that orients to a shared future across generations for all our relations (human kin, alongside the four-legged, winged, finned, rooted and nonrooted relations (14,63) in ways that respond to converging and increasingly urgent calls for all sectors to work together to 'heal the web of life' (56) and 'make peace with nature' (10).

It is important not to be naïve about the challenging power-dynamics associated with these opportunities and calls for change. Powerful influences are at play, leveraging hundreds of years of colonising, racist and capitalist processes, to ensure that entrenched notions of competition, supremacy, disconnection and individualism are given primacy. Countering this are long-standing and converging commitments to reciprocity, connections and interrelatedness, each reflected, in different ways, in the Indigenous worldviews, spiritual perspectives and ecological perspectives that are receiving renewed attention (14,28,29,61).

While not new, this perspective reinvigorates calls for an eco-social approach to healthy settings bringing together people, place and planet, and, at the same time, incorporating Indigenous and spiritual perspectives and approaches. Can we, for example, combine the concept of healthy settings such as cities and communities, schools, hospitals and workplaces with their complementary 'sustainable' or 'green' equivalents?

The good news is that linking 'healthy settings' with 'green settings' (64) creates a new realm of potential synergies among health, equity and ecosystem considerations, with many health co-benefits stemming from sustainable ways of life. One way to consider the fertile interface between different types of settings and the different levels of action is to consider the interface of 'healthy settings' and 'green settings' in an approach that was developed in conjunction with Population Health in British Columbia (BC)'s Northern Health Authority (65) – see Figure 1 in the Supplementary file 1.

Combining 'healthy' and 'green' settings encourages new conversations, creating points of synergies between the healthy edge of 'green' (environmental) settings such as parks (66) and watersheds (62,67), with a reinvigorating commitment to pay more attention to the green (ecological) edge of traditional healthy settings work in healthy schools, workplaces, healthcare or cities, communities or islands (68). In doing so, we need to engage with what might be seen as 'unusual allies' (58,59), including the broad spectrum of faith congregations and spiritual communities, as well as among Indigenous people.

Next generation practices are already emerging – reflecting a new era of health-promoting approaches and place-based connections spanning ecosystems, community and health and well-being in ways that honour Indigenous knowledges within cities, islands, and regions (28,65,68). Nesting health promotion within healthy eco-social settings creates synergies for a healthy, just, and sustainable future (69) of healthy 'One Planet' communities (70).

Implications for the education and training of 'planetary health promoters' and the incorporation of this within professional education and training are the focus for the international collaboration (and future position papers) being developed by our IUHPE Global Working Group on Waioria Planetary Health.

Conclusion

Our task as health promoters is not to predict the future of health, but to imagine and then try to create the future for health that we wish to achieve – our preferable future for health. If our vision is one of health for all within the ecological limits of the Earth, then we have to ask how that is to be achieved.

It will require a markedly different society and economy, driven by a set of values that are radically different in their profound recognition of our reciprocity and interdependence. Considering both Indigenous and spiritual perspectives in arriving at a new, healthier set of relationships between people and the planet in the future is essential to our next-generation of health promotion practice.

The challenge for planetary health promotion in the 21st century is simple:

'*How do we improve the health of the population – especially the health of the most disadvantaged*

and vulnerable – while making peace with the Earth?'

Author note

Margot W. Parkes is now affiliated to Department of Preventive and Social Medicine/Te Tari Hauora Tūmatanui, Dunedin School of Medicine/Te Kura Hauora O Ōtepoti, University of Otago/Te Whare Wānanga O Otago, Dunedin, New Zealand.

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ORCID iD

Trevor Hancock https://orcid.org/0000-0003-4408-4616

Supplemental material

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Notes

1. Readers with long memories will recognise that this is a re-statement of the World Health organisation's 1977 goal of 'Health for all by the Year 2000'. We did not achieve it then, we must achieve it now.
2. A generation is roughly 30 years – 'three generations per century (33 years each) for male lines, 3 1/2 generations per century or seven in two centuries (29 years each) for female lines' Excerpted from 'How long is a generation? Science provides an answer' by Donn Devine, CG, FNGS on the International Society of Genetic Genealogy Wiki https://isogg.org/wiki/How_long_is_a_generation%3F_Science_provides_an_answer
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People-Planet-Health: promoting grassroots movements through participatory co-production

Claudia Meier Magistretti[1], Jake Sallaway-Costello[2], Shadhaab Fatima[3] and Rachel Hartnoll[3]

Abstract: The threat of anthropogenic climate change demands immediate action to prevent further damage to human health and fragile natural ecosystems. This process of change might locally have already begun, led by grassroots organisations around the world. Conceiving their actions as a form of salutogenesis, these organisations build a Sense of Coherence to empower communities to participate in the potentially overwhelming challenge of planetary health. People-Planet-Health aims at giving voice and visibility to those groups and their actions. Contributors will further be invited to co-create a position paper, to inform the revised WHO Global Strategy for Health Promotion.

Keywords: Salutogenesis, climate change, participation, planetary health, Indigenous health, Anthropocene

Anthropogenic climate change threatens health by degrading ecosystems on which human life is dependent (1). Rising temperatures, species extinction, zoonoses, and other aversive effects of the Anthropocene increase health risks, causing direct damage to human health through migration, malnutrition, new epidemics and psychological stressors associated with overwhelming change (2). It is estimated that 'globally, 23% of total deaths could be prevented through healthier environments' (3). Numerous legislative actions taken at national and supranational levels have provided populations with aspirations for sustainable development, but have not realised the systematic change required to generate measurable improvements in human health or protection of ecosystems. In this sense, top–down approaches to climate change mitigation have thus far failed to build capacity for change.

However, the process of sustainability innovation has already begun, through the actions of grassroots activists around the world. This commentary draws attention to the work of grassroots groups, to reframe planetary health as a global salutogenic process of change. Recognising both the willingness and potential presented by these groups in bringing about planetary health, but also the barriers they face in conducting, upscaling and coordinating their work, we call on health promotion practitioners to support grassroots actions, contributing to a participatory process of planetary salutogenesis. The commentary further invites participation in People-Planet-Health: a novel knowledge exchange initiative giving voice and visibility to those groups through global co-production of a position statement on planetary health, to inform policy development activity of the World Health Organization.

Planetary health

Threats to human health and the vitality of ecosystems, by climate change, are inextricably linked, demanding new discourses concerning health

1. Lucerne University of Applied Sciences and Arts, Lucerne, Switzerland.
2. University of Nottingham, Nottingham, Nottinghamshire, UK.
3. Birmingham City University, Birmingham, West Midlands, UK.

Correspondence to: Claudia Meier Magistretti, Lucerne University of Applied Sciences and Arts, Werftestrasse 1, 6002 Lucerne, Luzern, 6002, Switzerland. Email: claudia.meiermagistretti@hslu.ch

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in the Anthropocene (4). Characterised as the 'new science for exceptional action' (5), planetary health is a holistic conception of wellbeing, assuming human and environmental interdependence. Viewing humans as custodians of ecosystems, and ecosystems as providers of essential resources for human wellbeing, planetary health challenges anthropocentric discourses on sustainability, re-centring the earth as a living material on which life is dependent (6). This reconceptualisation is already happening at a grassroots level and can be explored through a salutogenic lens.

The salutogenic approach to planetary health

The theoretical framework we propose is the theory of salutogenesis, proposed by medical sociologist Aaron Antonovsky. Salutogenesis focuses on how health may be created, maintained, and restored, defining health not as a normative-static state, but as a learning process, on a continuum between the poles of health-ease and health-disease. Individual experiences responding to life stressors influence the direction of movement between these poles. If stressors can be successfully addressed, a movement towards health-ease is achieved. Without this, tensions occur which may bring about movement towards health-disease. Movement along the continuum depends on the resources that can be accessed to cope with demands, and Sense of Coherence (SOC). Antonovsky (7) defined the concept of SOC as a global orientation that expresses the extent to which one has persuasive, enduring, though dynamic feelings of confidence concerning:

- Sense of Comprehensibility: that requirements from one's internal and external environments are structured, predictable, and explicable.
- Sense of Manageability: that resources are readily available and accessible for one to meet these requirements.
- Sense of Meaningfulness: that the challenge of meeting requirements is worthy of investment and active engagement.

Sense of Coherence is measured by SOC scales and has been proven to predict and explain physical and mental health, as well as health behaviour and the management of various conditions (8). A strong SOC is congruent with improved wellbeing, ability to access and create resources, and coping with acute and chronic stress (9). In salutogenic theory, health is created from interactions between resources and environments, in a lifelong learning process that ideally leads to a movement towards health-ease. This corresponds to recent sociological theories of new materialism that underpin current developments in theoretical frameworks for planetary health. Fox and Alldred (10) state that health is never an outcome but rather a process of 'becoming-healthy', or 'healthing' not only of individuals but of assemblages of individual-environmental entities. Considering theoretical congruence of these ideas, we conceptualise planetary health as progressing beyond normative anthropocentric discourses of health, towards a learning process of interactions between populations and environments that are valued as equal, interdependent entities. This process may be understood as 'planetary salutogenesis': creating and maintaining both the sustainability of natural ecosystems and human wellbeing through strengthened Sense of Coherence, and novel relationships with resources.

Planetary salutogenesis through grassroots activism

Across the globe, local grassroots initiatives are undertaking actions directed towards sustainability and planetary health. These groups do not value the environment as an object to be influenced, owned or shaped, but rather understand it as a co-environment with which they interact in the interest of commanding greater quality of life for local people, and continued vitality of ecosystems. Thereby, they act according to the principles that theories of new materialism and salutogenesis propose: by 'healthing' with consideration for sustainability, the groups build and strengthen Sense of Coherence.

- They translate overwhelming, enormous planetary threats into local projects, giving them context that empowers people to take action to solve those challenges (Sense of Comprehensibility).
- They provide a tangible base upon which to act, by innovating physical solutions through which people can gain a sense of control (Sense of Manageability).

- They give the challenges local significance, motivating people to engage and address global threats in ways which speak to their local interests (Sense of Meaningfulness).

In creating Sense of Coherence (SOC), the initiatives create human health, as SOC is a predictor and indicator of the physical and mental health of individuals and groups (11). The initiatives have multiple relevances for health promotion. Strengthening SOC, they act as a buffer for environmental stress, and create both immediate and ongoing benefit for the individuals involved. Although their impact on sustainability indicators is typically unmeasured, the grassroots initiatives contribute to planetary health by forming new, tangible linkages between previously disparate concepts, such as sexual health, sustainable consumption, eco-friendly housing, food waste, quality of healthcare, and other challenges. Some examples of these linkages that promote planetary salutogenesis represent diverse global geographies and topical interests.

- The Uganda Youth and Adolescence Health Forum has developed participatory approaches connecting reproductive and planetary health. Amongst many diverse empowerment activities, the project leaders describe the impact of poverty on access to sanitary pads, and the subsequent effect this has on girls' early school dropout rates. 'We believe that women can be agents of change in their communities and have engaged them in more sustainable and environmentally friendly measures towards addressing their sexual and reproductive health. For example, we train young women and girls in the making and use of reusable sanitary pads which are made from environmentally friendly and biodegradable materials.' The organisation hopes to deliver more sustainable health promotion programmes that illustrate intergenerational links between climate change, other health risks, and reproductive health.
- Sustanarea, an initiative in Brazil, is a University Extension Program of the School of Public Health at the University of São Paulo. Its objective is to improve accessibility to, and normalisation of sustainable diets for the Brazilian population. It does this through promotion of dietary behaviour change, by reducing red and processed meat consumption, encouraging increased fruit and vegetable consumption, reducing purchasing of ultra-processed foods, and advocating production of food with minimal environmental impact. The group engages in capacity-building for planetary health, via co-production of projects between public health academics and local communities in urban São Paulo.
- In Sri Lanka, the Goodness Foundation focuses on activities centred around the empowerment of individuals and communities in disadvantaged regions, by delivering a holistic programme of sustainable housing, school supply packs for disadvantaged children, and medical and dental care to 180,000 rural villagers. The organisation also runs sustainable business training in disadvantaged rural areas. Sharing their vision, the project leaders stated: 'Sustainable development and the concept of planetary health should embrace traditional ways of living that draws on generations of local knowledge to live in harmony with nature while maintaining good long-term quality of life.'
- The volunteers of the Real Junk Food Project Central, in the UK, prepare meals from edible 'waste' food from supermarkets and wholesalers, and distribute them through their inclusive community cafes in economically deprived urban areas. Customers are invited to 'Pay As You Feel' for their food, and payment is accepted in 'time, cash, skills, or imagination', referring to the initiative's use of asset-based approaches and their holistic valuation of material in community development. The project has saved approximately 300 tonnes of edible food since its founding in 2017, and has used it to produce nearly 600,000 meals.

People-Planet-Health

Launched in July 2020, the People-Planet-Health programme aims to give voice and visibility to these groups and their work, while encouraging them to share their actions, thereby supporting capacity-building within and between grassroots initiatives. People-Planet-Health, initiated by the first and the second authors, is supported by Lucerne University of Applied Sciences and Arts and conducted in partnership between Lucerne University, the

University of Nottingham, and the International Union of Health Promotion and Education. In this project, groups undertaking grassroots activities are invited to share short stories about their work towards, and vision of, planetary health. With respect for the dynamic, organic, and unique cultures of grassroots movements, initiatives are personally contacted, or may join through word of mouth. This process is facilitated by Planetary Health Officers, who – as health promotion students – are familiar with both the concept of grassroots activity and the visions of health-promoting organisations.

The initiatives are asked to describe what they do, what they intend to achieve, and how their visions of planetary health can be realised, submitting their short descriptions in eight languages. Aligned with Antonovsky's open framework for SOC, and Fox's flexible materialist conception of 'healthing', initiatives are welcomed to share their contributions following a simple self-audit of their actions according to salutogenic principles. The stories contributed are featured on a website and social media platforms, sharing examples of grassroots activity and their relevance to planetary health.

At the beginning of 2021, grassroots initiatives from all inhabited continents had joined the programme. Their topics and objectives cover a wide range of initiatives tackling food waste, sexual health, health networking, knowledge exchange, sustainable entrepreneurship, environmental education, and many others. The aforementioned examples give insight on what can be further read on the programme website (12). A second stage, initiated in June 2021, invites contributing initiatives to co-create a position statement to inform the revised WHO Global Strategy for Health Promotion.

A healthier future: policy and practice

As the leaders of the Te Whare Hauora o Te Aitanga A Hauiti project (Aotearoa) state: 'The future of sustainable well-being for people and the planet, as evidenced by the chaotic international response to the COVID-19 pandemic, is unachievable without the establishment of a world commonwealth in which all nations are in agreement, and in which the autonomy of its state members and the personal freedom and initiative of the individuals that compose them are safeguarded' (12). Health promotion must support realignment of human connections with the environment, by conceiving of new ways in which sustainable activity might take place, not only around humans, but as humans being part of the process. We conceive of this as the outcome of planetary salutogenesis, and call upon the health promotion community to support grassroots groups to progress their actions towards it, particularly in reference to accessing resources, measuring impact and upscaling their activity. How this might be achieved will be the central focus of the second phase of the People-Planet-Heath project. In a common participatory writing and discussion process, all projects participating were invited to co-create a position statement for the new WHO Health Promotion Strategy that will be more than just the sum of the involved projects: it will create new insights, in a novel way, from the cooperation of a global yet local network of grassroots groups. The position statement will serve as an initial participatory global framework for supporting and promoting the process of planetary salutogenesis, calling upon health promotion practitioners and global policymakers to value grassroots contributions in the creation of planetary health.

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Original Article

Re-envisioning health promotion: Thinking and acting salutogenically towards equity for historically resilient communities

Fungisai Gwanzura Ottemöller[1], Tulani Francis L. Matenga[2], J. Hope Corbin[3], Humaira Nakhuda[4], Peter Delobelle[5], Christa Ayele[6], Nikita Boston-Fisher[7], Stephanie Leitch[8], Josette Wicker[9] and Oliver Mweemba[2]

Abstract: This paper explores how the salutogenic theory can enable us to re-envision health promotion work with marginalized communities, towards an approach that acknowledges and honours their resilience. We use the three core concepts in Antonovsky's salutogenic model of health – sense of coherence, generalized resistance resources and specific resistance resources – to explore the theory's relevance to health equity, thus presenting new opportunities for how we might radically re-evaluate current health promotion approaches. We conclude that a more equitable health promotion requires increased participation of marginalized communities in shaping their futures and suggest a new model for historically grounded salutogenic health promotion.

Keywords: Health equity, salutogenesis, health promotion, resilient communities

Introduction

Addressing health equity is a fundamental concern of the field of health promotion. The core action areas of health promotion aim to address inequity in health by influencing public policy, addressing environmental conditions, organizing communities, reorienting health services and developing personal skills (1). However, despite these goals, much of this work is funded and framed in ways that pathologize communities of colour, indigenous peoples and other marginalized groups. Discourses and interventions have been paternalistic in their approach and focused on 'helping' vulnerable communities, with an emphasis on 'need', and a deficit orientation.

Antonovsky (2) offered helpful critiques of health promotion's persistent focus on pathology. His pioneering salutogenesic theory has provided the field with a framework for shifting thinking away from negative factors that cause disease[1] towards positive factors that generate health. This approach is consistent with Morgan and Ziglio's (3) health asset model where assets are 'resources that individuals and communities have at their disposal, which protect against negative health outcomes and/

1. University of Bergen, Faculty of Psychology, Bergen, Norway.
2. University of Zambia, Lusaka, Zambia.
3. Western Washington University, Bellingham, Washington, USA.
4. IUHPE Student and Early Career Network, Toronto, Ontario, Canada.
5. University of Cape Town, South Africa; Vrije Universiteit Brussel, Brussels, Belgium.
6. IUHPE Student and Early Career Network, Philadelphia, Pennsylvania, USA.
7. McGill University, Montreal, Quebec, Canada.
8. IUHPE Trustee for Partnerships, NARO; University of Suffolk, United Kingdom; WOMANTRA, Trinidad and Tobago.
9. IUHPE Student and Early Career Network, Seattle, Washington, USA.

Correspondence to: Fungisai Gwanzura Ottemöller, University of Bergen, Faculty of Psychology, Alrek, Bergen, Vestland 5020, Norway. Email: fungi.ottemoller@uib.no

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or promote health status. These assets can be social, financial, physical, environmental or human resources' (3, p.18). Significant work has been done to extend and examine the potential of a salutogenic orientation to promote health at the different socio-ecological levels (1).

In this paper, following calls for exploration of how we can further deconstruct hegemonic epistemologies (4), we argue that salutogenesis offers an important perspective in promoting health at the community level. By rejecting the unmerited pathologizing of traditionally oppressed communities as a starting point in our analysis, we allow ourselves the possibility to re-envision our work. We move to unearth or create approaches that acknowledge and honour the resilience demonstrated by ordinary actors (current and historic) in their pursuit of well-being. We activate our peers in the field to reprioritize health equity in meaningful ways. Antonovsky instrumentalized his theory in the Salutogenic Model of Health (SMH) and in this paper we use the model's three core concepts (2) – sense of coherence (SoC), generalized resistance resources (GRRs) and specific resistance resources (SRRs) – to explore their relevance to discussions of health equity within diverse contexts and what lessons are most valuable for the transformation of current health promotion approaches.

Sense of coherence (SoC)

As enshrined in the World Health Organization (WHO) Constitution (5), the highest attainable standard of health is the fundamental right of every human being. To improve the conditions in which people live, focus has been on mitigating the unfair, avoidable and remediable differences in health outcomes among vulnerable populations. This approach aims to be inclusive of disenfranchised groups and individuals, such as people of colour, Indigenous peoples, the LGBTQ+ community, people living with mental and physical disabilities and any person who is denied the chance to achieve their full potential. People, their health needs and overall experiences are fundamentally shaped by gender, race, class, sexuality, culture and citizenship, as well as by specific socio-political and historical structures (6,7). While these factors are recognized on some level, health promotion practice is still planned, funded and reported in deficit and 'needs'-centred ways without the requisite attention being paid to underlying causes or equitable solutions. If we are going to reorient health promotion practice salutogenically and build on authentic empowerment, we must first recognize the strengths, resilience and solutions within communities in managing their own health. Such an orientation can build a sense of coherence through truth-telling about historical processes of harm and neglect, while highlighting uplifting stories of survival and resilience based on the actual experiences of the communities in question.

As Eriksson and Lindstrom (1) observe, health is created by complex relations between the individual and society and by an individual's ability to identify and realize aspirations, as well as to satisfy needs and cope with their environment. SoC is a 'global orientation to view life as structured, manageable and meaningful... which leads people to identify, benefit, use and re-use resources at their disposal' (8, p.95). SoC is made up of three dimensions: comprehensibility, the ability to understand challenges faced; manageability, identifying the resources or assets to cope with these challenges; and meaningfulness, the motivation to engage with life's challenges (9). The ability to manage stress in a globalized world characterized by rapid social and environmental changes is crucial for the maintenance and development of health. Below we use the three dimensions of SoC to interrogate whether current health promotion approaches are *relevant enough* for marginalized communities.

Comprehensibility

A recognition of histories of oppression and structural inequality is central to understanding why marginalized communities continue to be disenfranchised and experience disproportionately negative health outcomes, in both mind and body. The trauma experienced by Black and Indigenous peoples, for example, is well documented. It is associated with the history of European colonization, which has stripped communities of their cultures, customs and language(s) – a deprivation that is further exacerbated by racism, state oppression and internal conflict (10,11). Historically, health promotion has had very little engagement with interrogating the lived experiences and realities of marginalized groups. The absence of this historical context leaves much unsaid about who bears

responsibility for current inequities (12), and to what extent our current frameworks reinforce unequal power relations.

Spencer et al. (13) conducted a critical frame analysis to unpack the UN's Sustainable Development Goals in relation to key health promotion indicators. This revealed a number of assumptions and 'hidden' value systems that codified hierarchy through language, and relied upon shared meanings of inequity (13). Key development terms such as ('developed' and 'developing') used to describe the economic status of countries, for example, are responsible for sustaining the primacy of Global North and other global powers. 'Developing' nations are positioned as recipients of action (i.e. those that need 'developing' or aid), while 'developed' nations and other powerful actors position themselves as having something positive and valuable to contribute (13). This systemic lack of recognition prompts us to ask, how can we enable marginalized communities to take control of their health without first examining the circumstances that have disadvantaged them?

Antonovsky argues that marginalized communities can often feel subjugated by hostile actors and the powers that be, causing them to experience ongoing stress as a direct result of lack of autonomy (14). As we seek to move the health promotion discipline forward, we must acknowledge the erasure and deception in our current narratives around health outcomes. Super *et al*. (15) state that the salutogenic model includes behavioural and perceptual mechanisms. The behavioural mechanism highlights the possibility to empower people through building their capacity to use their resources in stressful situations, while the perceptual mechanism implies that, for people to deal with everyday life stressors, they must be able to reflect on their understanding of stressful situations and identify available resources. They suggest that these interdependent empowerment and reflection processes may be relevant for health promotion activities that aim to strengthen SoC (15).

Manageability

According to Antonovsky (2), manageability refers to the belief that we have the resources to cope with the stressors we face. The impacts of colonialism, heteropatriarchy and capital/GDP-focused development have not only systematically compromised the ability of marginalized communities to make sense of their circumstances but also robbed them of the crucial material resources needed to manage their day-to-day lives. Resources and people lost to colonialism and slavery, power and autonomy lost to debtors, unfair trade policies and laws, social and educational services eroded by structural adjustment programmes – all have trickled down through generations of history and to the people and communities who now occupy marginalized identities (13,16,17). These deprivations are central to the social determinants of health and are explored in later sections of this paper. Généreux and colleagues (18), in their paper on strengthening adaptive capacities of individuals and communities in times of pandemic, argue that community resources that are made available to help individuals deal with stressful situations are important to give voice to their personal experiences and share what they have learned to bring relational value. These narrative grounded insights, and others like these, can be used to inspire community-driven strategies to deal with stressors.

Meaningfulness

Meaningfulness is considered the most important factor in determining a strong SoC: when a stressor or challenge is confronted and understood, and resources to cope are identified, what remains is whether there is the required motivation to engage with the process towards an achievable and satisfying end (2). As previously mentioned, health promotion and development are grounded in dominant discourses from the Global North. It is widely accepted that public health and medical interventions introduced by European colonizers and missionaries saved millions of lives in the Global South (19). Not enough attention has been paid to diseases brought in by colonialists, which in some regions wiped out Indigenous populations, or the lifestyles introduced that destroyed healthy Indigenous lifestyles. Moreover, the framing of health as the absence of disease has largely ignored indigenous and traditional ways of healing.

As we seek to move forward, how can we acknowledge erasure and deceptions in our current narratives of the past? How can we be realistic about the lack of and inappropriateness of resources,

and collaboratively craft visions of the future that uplift and build on community resilience and Indigenous and subaltern ways of knowing, and centres bodily autonomy and planetary well-being?

Generalized resistance resources (GRRs)

GRRs are 'the characteristics of a person, a group, or community that facilitate the individual's abilities to cope effectively with stressors and contribute to the individual's sense of coherence'. These resources can be linguistic, 'material, knowledge and intelligence, ego identity, coping strategies, social support, commitment and cohesion with one's cultural roots, cultural stability, religion and philosophy' (20, p.57). The quantity and quality of GRRs an individual is able to access has a direct impact on the development of their SoC, and thus their quality of life. Antonovsky (21, p.9) referred to GRRs as 'phenomena that provide one with sets of life experiences characterized by consistency, participation in shaping outcomes and an underload–overload balance'. These life experiences contribute to the development of SoC. Consistency refers to the order and structure in one's environment and provides the basis for comprehensibility; load balance is related to the balance between the resources available and the demands faced and is the basis for manageability; and participation in shaping outcomes refers to autonomy and control over one's life and is the foundation for meaningfulness (20).

There are various ways in which GRRs can be contextualized and it is significant to note that how these resources are presented to an individual influences the meaningfulness of their experience and subsequently shapes outcomes (22). Mittelmark *et al*. (23) refer to an illustration by Bengt Lindstrom, depicting an individual traveling across the 'river of life' with a backpack full of GRRs that have been gathered over time. They explain that GRRs are then readily available for an individual to engage when needed, to manage tension and avoid stress (14). Examples of GRRs are found in descriptions of social capital and community resilience, in the disaster relief and management literature (see e.g. (24–26)), and social science and community psychology (see e.g. (25,27)).

Examples of social capital as a community GRR are found in studies documenting empowerment processes in communities and neighbourhoods (28), Aboriginal youth health (29) and the development of Community Action Networks under COVID-19-induced lockdown restrictions in South Africa (30). Social capital has been defined as the ability to secure benefits through membership of networks and other social structures (31). This definition distinguishes two components: a relational element connected to the social organizations of which the individual is a member, and a material component related to the resources accessible to the individual through group memberships (32). Hawe and Shiell (32) suggest that social capital's political aspects may have been underrecognized, and need to be positioned in relation to other concepts such as sense of community and capacity-building. The concept has, however, gained much traction and is now firmly embedded in the health promotion literature. Sagy and Mana (33) define 'sense of community coherence' as the tendency of individuals to perceive their community as comprehensible, meaningful and manageable. They refer to reported positive relationships between a strong sense of community coherence and levels of resilience to stressful events. In their work with Palestinian Muslims and Christians in Israel, they examined the interplay between sense of coherence and inter-religious relations, showing how sense of community coherence is related to the perception of shared narratives of collective group history (33).

Idan et al. (20, p.57) listed 'knowledge, commitment and cohesion with one's cultural roots and cultural stability' as GRRs. Knowledge gained through education is an important GRR that helps build and shape communities and their environments. Unlike traditional education which kept young people embedded in their communities (34), institutionalized education was used by colonial powers as an instrument of domination, oppression, subjugation and exploitation (35). It aided the reproduction of Western ways of knowing at the expense of traditional and indigenous knowledge, depriving communities of the GRRs they needed to help them cope and thrive in these newly constructed and alien environments (34,36).

Mavhunga (34) argues that traditional African education was integrative and educated the mind, body and spirit (10). Western education has disrupted local systems, leaving young people to be educated outside of their cultures and communities. Nwalutu (10) contends that post-colonial education

systems remain as relics of colonialism and advocates for an 'urgent ... shift towards locally planned and executed educational programs and policies that are based on the people's socio-cultural, environmental and experiential realities'. Mavhunga (34, p.451) provides an example from the Zimbabwean/African context and suggests a curriculum based on 'the philosophy of unhu/ubuntu, rooted in African culture, characterised by qualities such as 'responsibility, honesty, justice, trustworthiness, hard work, integrity, a cooperative spirit, solidarity, devotion to family and the welfare of the community'. These examples of GRRs are intrinsically embedded in the contexts within which people can facilitate the creation of enabling environments that build strong SoC and lead to improved health and well-being. Despite the less-than-ideal circumstances many marginalized communities experience, there are still examples of resilience and thriving that need to be amplified and further explored with the same scientific rigor as other examples cited and studied within the Global North.

Specific resistance resources

Mittelmark et al. (23) underline the importance of differentiating between two concepts from the SMH, generalized resistance resources (GRRs) and specific resistance resources (SRRs). GRRs refer to inherent characteristics in an individual (or group) whereas SRRs are resources outside the individual (or group) that can be utilized to help cope with challenges. SRRs are situation specific and instrumental (23, p.71); they are '[...] optimised by societal action in which health promotion has a contributing role, for example, the provision of supportive social and physical environments'. Both GRRs and SRRs can be understood as health assets (see Morgan and Ziglio (3)) as they contribute to enabling individuals and communities to deal with challenges and to promote health and well-being.

Health, social welfare, education and political systems around the world are dominated by models developed in the Global North. Many of these models are neither comprehensible nor accessible to populations in large parts of the globe but are accepted as the gold standard because of the capitalist and neo-liberal models that dominate our international institutions. The Global North's hegemony over what promotes health and well-being has long side-lined alternative knowledges (37). However, health models are emerging (38) to enable communities to access SRRs that are not only culturally appropriate but accessible and affordable.

Medical pluralism is supported by the WHO Traditional Medicine Strategy 2014–2023 (39), acknowledging the significant role traditional medicine plays in the Global South, and the widespread use and acceptance of complementary medicine in the Global North (39). This recognition of alternative ways of restoring and promoting health is crucial to support culturally relevant and accessible health-related SRRs. However, it is important to note the hierarchy in resource access, where certain SRRs, such as traditional medicine, are only considered acceptable when approved by institutions in the Global North. Previously, much of this knowledge was oral and handed down over generations, but countries like China and India have managed to promote alternative medicine in more integrated and institutionalized ways, with universities and colleges providing qualifications for holistic ways of treating mind, body and spirit (39). Traditional medical practitioners are appropriate SRRs for the contexts in which they are situated, and communities have the necessary GRRs to access them when needs arise.

Research on medical pluralism reveals that in many African countries, traditional healers still play an important role (40). Biomedical institutions are often not readily accessible and predominantly focus on somatic symptoms, and thus there is a need for SRRs congruent with local beliefs and traditions to help with spiritual or social stressors (40). Exercising medical pluralism indicates that these communities have high SoC and the necessary GRRs to access SRRs appropriate to their needs.

Unfortunately, in most contexts in the Global South, social welfare systems are largely based on models developed and implemented during colonial eras. In most traditional societies, communities looked after one another, for example by providing support for widows and orphaned children. The HIV/AIDS pandemic eroded traditional social support systems in many countries due to the premature deaths of many young adults. Botswana, for example, was hard hit by the pandemic, with up to 23% of children losing one or both parents (41). A local non-governmental organization (NGO) identified the need for these children to access

psychosocial support, and developed a culturally relevant therapeutic method that is now implemented country-wide (41). Earth therapy enrols orphaned children from the same village in age cohorts in a 16-day wilderness-based therapeutic retreat and a follow-up programme for up to three years. The retreat uses rites of passage and rites of affirmation (similar to traditional initiation rites) to help cohorts build resilience, develop relationships and build community (42). The follow-up programme includes caregivers, community leaders and chiefs, social workers and police – providing a holistic support system (41). This is an example of how locally developed culturally appropriate mental health programmes are important SRRs for young people experiencing distress and can lead to positive sustainable outcomes.

Another example is the Office of Hawaiian Affairs' (43, p.1) introduction of a Bill to address 'the significant and pressing mental health needs of the Native Hawaiian community'. They recognized that Indigenous Hawaiians are disproportionally affected by mental health associated outcomes and risk factors (depression, abuse, suicide etc.), and yet they underutilize mental health facility SRRs (43). Based on evidence that facilities aligned with Indigenous Hawaiian cultural identity, values and beliefs promoted significantly better mental health outcomes, the authorities concluded that there is a need for facilities that are more compatible with Indigenous Hawaiians' conceptualizations of illness, health and well-being (43).

Māori health models in New Zealand also offer a noteworthy alternative example. For instance, the *Te Pae Mahutonga* model (Southern Cross Star Constellation) incorporates four key tasks for health promotion: *Mauriora* (cultural identity), *Waiora* (physical environment), *Toiora* (healthy lifestyles) and *Te Oranga* (participation in society). They are situated within two key orientations for how the work should be done: with *Ngā Manukura* (community leadership) and *Te Mana Whakahaere* (autonomy) (44). This model, embraced by the New Zealand Health Ministry, is an example of a foundation from which truly supportive health services can be delivered.

The ability to use SRRs depends not only on their relevance to communities but also on how their repeated use is able to resolve challenges and create experiences that are meaningful (22). Current micro and macro systems need to be wary of creating passive relationships in how resources are used to achieve specific outcomes (22). As shown in the examples above, SRRs and GRRs designed and developed within a culture or community create an experience that is integrated with the perception and understanding of what is meaningful (22) and cannot always be produced or replicated by outsiders. For example, a pilot programme to address diabetes among South Asian Muslim women in Canada involving a physical activity intervention at a mosque revealed that participation was influenced by the provision of a convenient and accessible setting within a structured network that actively supported their religious and cultural needs (45). Active relationships thus become important to engage communities in how a resource can be developed and adapted (22). Strengthening the relevance and meaningfulness of SRRs strengthens the SoC of individuals and communities (22) and the way in which subsequent interactions between GRRs and SRRs are viewed as relevant and usable.

Discussion

In 1996, Aaron Antonovsky proposed the salutogenic theory as a guide for health promotion (2); 25 years later, this paper attempts to outline a reassessment of health promotion's health equity agenda. We draw on the interdisciplinary roots of the field and use a historical and decolonial lens to examine our limited engagement with the historical roots of health inequity. We argue for a more salutogenic orientation to health promotion and show how its key concepts – SoC (and its dimensions of comprehensibility, manageability and meaningfulness), GRRs and SRRs – can help us highlight the strengths of marginalized communities.

We outline the historical and systemic oppression of communities of colour, Indigenous peoples and other traditionally marginalized groups with the aim to honour these communities' resistance to oppression and to highlight their resilience. Our discussion of SoC examines how the historical inequities founded on deliberate efforts to disenfranchise populations and erase their sense of personhood continue to impact these communities. For example, social justice movements like Black

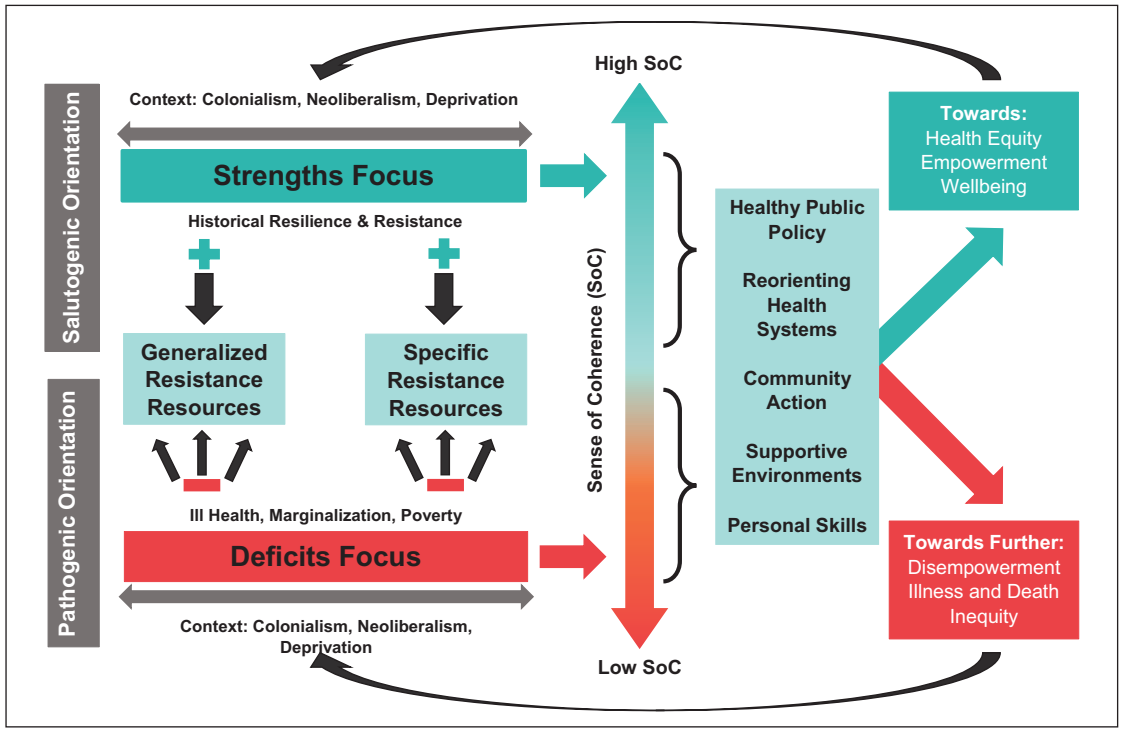

Figure 1. A salutogenic versus pathogenic approach to promoting health with historically resilient communities.

Source: authors' own elaboration.

Lives Matter reveal that there is still much to be done, and that health promoters have an important role to play (46). We challenge the field to engage reflexively and critically on how, despite good intentions, our work is still embedded in neo-colonial agendas. We discuss how GRRs such as social capital and education can provide consistency and opportunities for participation that enable communities to make sense of their worlds, cope with challenges and build health and well-being. We highlight that SRRs such as culturally relevant projects and programmes developed within and with communities have a higher likelihood of success than those imposed from outside.

To move the health promotion discipline forward we must think salutogenically to help communities identify and activate health assets to shift the community engagement paradigm, amplifying and building on locally developed initiatives that work well.

Figure 1 below depicts the impact of a historically grounded salutogenic approach versus a pathogenic approach to health promotion. In both cases, health promotion is taking place within a historical context of colonialism, neoliberalism and intergenerational deprivation. A salutogenic orientation, which builds on historic and modern resilience and resistance, positively contributes to GRRs and SRRs and strengthens SoC. When this approach is implemented through the five action areas of health promotion, we move towards greater health equity, authentic empowerment, and well-being. The status quo is depicted as the pathogenic orientation, which is also situated in the historical context of colonialism, neoliberalism and intergenerational deprivation – but this approach frames communities in terms of deficits, which negatively impacts GRRs and SRRs and contributes to lower SoC. When this orientation is the basis of health promotion action, it results in further disempowerment, illness, death and inequity. Either

approach feeds back and reinforces itself – the salutogenic orientation builds on itself positively, while the pathogenic orientation reproduces disempowerment and further fails to meet the needs of communities.

Conclusion

Developing equitable programmes, systems and institutions requires that we openly acknowledge alternative ways of knowing, take the role of supplicant, ask communities to lead in matters that affect their lives, and advocate for a truly bottom-up and participatory approach. By acknowledging how we have overlooked the deep-rooted causes of health inequity we begin to shift the paradigm and build a radical health promotion that truly works towards equity for all.

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ORCID iDs

Fungisai Gwanzura Ottemöller https://orcid.org/0000-0002-6584-4090

Peter Delobelle https://orcid.org/0000-0002-9016-7458

Note

1. Antonovsky (2, p.14) considered the dichotomous classification health/illness to be inappropriate for health promotion and proposed a model where individuals move between the health and disease continuum during their lives.

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Achieving SDGs and addressing health emergencies in Africa: strengthening health promotion

Davison Munodawafa[1], Handsome Onya[2], Mary Amuyunzu-Nyamongo[3], Oliver Mweemba[4], Peter Phori[5] and Aminata Grace Kobie[6]

Abstract: In 1986, the World Health Organization (WHO) convened the first Global Conference on Health Promotion held in Ottawa, Canada. This conference yielded the Ottawa Charter which defined health promotion as the process of enabling people to increase control over, and to improve, their health. A series of conferences followed and in 2005, WHO convened the Sixth Global Conference in Bangkok, Thailand, which yielded the Bangkok Charter for Health Promotion. This Charter for the first time expanded the role of health promotion to include addressing social determinants of health. Ministers of Health from 47 countries of the WHO Regional Office for Africa in 2012 endorsed the Health Promotion: Strategy for the African Region. This Strategy highlighted eight priority interventions required to address health risk factors and their determinants. In 2011, the Rio Political Declaration on Addressing Social Determinants of Health was adopted by Health Ministers and civil society groups to address inequalities and inequities within and between populations. The main action areas were good governance to tackle the root causes of health inequities; promoting participation and ownership; community leadership for action on social determinants; global action on social determinants to align priorities and stakeholders; and monitoring progress on implementation of policies and strategies. Health promotion has been prominent as part of disease outbreak response, including for Ebola and COVID-19. It has been an integral part of improving maternal and child health mortality and morbidity as well as TB, HIV/AIDS and malaria; and lately reducing the impact of noncommunicable diseases, namely diabetes, high blood pressure and cancer. While challenges continue in strengthening health promotion, there have been concerted efforts to place health promotion on the development agenda in countries through Health in All Policies (HiAP), capacity strengthening, monitoring and evaluation, and innovative financing policy options using dedicated tax from tobacco and alcohol, and road use.

Keywords: Capacity building (including competencies), communication (including social marketing, education campaign, media communications), community action, determinants of health, health literacy, health promotion

1. Midlands State University, Harare, Zimbabwe.
2. University of Limpopo – Turfloop Campus, Sovenga, Limpopo, South Africa.
3. African Institute for Health & Development, Nairobi, Kenya.
4. University of Zambia School of Public Health, Lusaka, Zambia.
5. World Health Organization, Brazzaville, Congo.
6. World Health Organization Regional Office for Africa, Brazzaville, Congo.

Correspondence to: Davison Munodawafa, Midlands State University, P Bag 955, Gweru, Harare, 11101, Zimbabwe.
Email: munodawafad@staff.msu.ac.zw

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Introduction

In 2015, the United Nations Member States adopted the 17 Sustainable Development Goals (SDGs) with 169 targets as a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity by 2030. SDG 3 is dedicated to health and well-being for all ages, and it has 13 targets. While only SDG 3 focuses on health, all goals are inter-related there by promoting an inter-sectoral approach that addresses a wide range of health risk factors and their determinants across population groups. Achieving SDG 3 will only be possible if action on other SDGs such as ending poverty (SDG 1) and zero hunger (SDG 2) among others, support SDG 3.

Health emergencies are increasingly becoming a major threat to the African continent's already weak health care delivery systems. The African population continues to face a myriad of challenges including poverty, hunger, AIDS, and discrimination against women and girls, as well as disease outbreaks from new and re-emerging pathogens. The SDGs are in direct alignment with the African Union's Agenda 2063 (1,2). Achieving the SDGs in Africa would require that strategies and actions that embrace good governance and equity are placed at the center of the policy agenda in order to address daily realities facing the African population. Health promotion practice promises to possess such strategies and actions.

Why health promotion?

The World Health Organization (WHO) Ottawa Charter (1986) defines health promotion as the process of enabling people to increase control over, and to improve, their health. The WHO Bangkok Charter for Health Promotion (2005) further defines health promotion as 'the process of enabling people to increase control over their health and its determinants, and thereby improve their health (3)'. Health promotion has proven tools and interventions that have the potential to promote, support and protect the African people and contribute toward achieving SDG 3. WHO considers health as both a fundamental human right and a sound social investment (4). Inequalities in health are rooted in inequities in society.

Millions of people in the African Region are living in extreme poverty and deprivation in an increasingly degraded environment in both urban and rural areas. In 2008, the WHO Commission on Social Determinants of Health Report (5) made three overarching recommendations, namely: (i) improve daily living conditions; (ii) tackle the inequitable distribution of power, money and resources; and (iii) measure and understand the problem and assess the impact of action (5). These recommendations are aimed at addressing the social factors leading to ill health and health inequities.

The state of health promotion in the African continent

Health promotion as a discipline and practice has been embraced by Member States in the African Region. The Region has been represented in most, if not all, of the nine WHO Global Conferences on Health Promotion held to date. In 2009, the continent convened its first WHO Global Conference on Health Promotion which was held in Nairobi, Kenya. Its theme was on Health Promotion and Development: Closing the Equity Gap, which explored the integration of health across development policies in both private and public sectors (6,7).

In 2011, countries of the WHO African Region participated in the World Conference on Social Determinants of Health (8) attended by Health Ministers, civil society groups and academics. The Global Conference outcome was the Rio Political Declaration on Social Determinants of Health, which agreed on implementing the following required actions:

1. Governance to tackle the root cause causes of health inequities;
2. Promoting participation and ownership: Community leadership for action on social determinants;
3. The role of the Health Sector, including Public Health Programs, in reducing health inequities;
4. Global action on social determinants: Aligning priorities and stakeholders;
5. Monitoring progress: Measurement and analysis to inform policies and build accountability on social determinants.

Strategic restructuring: establishing the Health Promotion and Social Determinants of Health (HPD) Unit

A sound organizational structure is a pre-requisite for the effective delivery of services, and the same is needed for health promotion delivery. In 2015, the Regional Director, WHO Regional Office for Africa established the HPD Unit under the Office of the Director of Programs and Management in order to ensure speedy and timely reaction from health promotion. This elevation also facilitated the integration of Health Promotion and Social Determinants of Health activities across technical programs and clusters within WHO and across Member States of the African Region. Ultimately, the HPD Unit has been visible in all decision-making regarding health emergencies including Ebola, Cholera, Zika, Yellow fever and recently COVID-19.

Development and implementation of the Health Promotion Strategy for the African Region 2012–2022

In 2012, Ministers of Health from the 47 countries in the WHO African Region endorsed the Health Promotion Strategy for the African Region 2012–2022 (9). This strategy was meant to respond to the emerging and re-emerging public health challenges facing the continent.

The eight priority interventions are: (a) strengthening the stewardship role of the Ministry of Health; (b) strengthening the national technical capacity for health promotion; (c) sustaining institutional capacity for health promotion at national, regional and local levels; (d) communication, social mobilization and advocacy; (e) gathering and disseminating evidence on best practice and effective health promotion approaches; (f) establishing sustainable mechanisms for innovative financing of health promotion to ensure adequate funding of interventions; (g) strengthening functional partnership, alliances and networks; and (h) strengthening community capacity for health promotion. It also defines the roles and responsibilities of Member States, WHO and partners in promoting, supporting and protecting health. Ultimately, the strategy also brings up resource implications as well as monitoring and evaluation.

The interventions identified in this Strategy are meant to address the preventable causes of disease, disability and premature deaths in the African Region using the life course approach. The intended outcomes are increased community health awareness, participation and empowerment; positive changes in health-related behaviors and societal structures; and evidence-based policies and legislations. A Progress Report (2015) on the implementation of Health Promotion: Strategy for the African Region (10) highlights progress in 13 countries that had a Strategic Plan of Action. Gambia established a Health Promotion Directorate to coordinate and manage health promotion activities, and South Africa and Botswana received technical support to establish innovative health promotion financing options along the lines of The ThaiHealth Promotion Foundation, Thailand (11).

Human resources for health promotion and capacity strengthening

The human resources for health remain a critical component for success in health delivery, and the African continent is no exception. Capacity building for human resources in health promotion remains a key area of need among African countries (4). While WHO leads in strengthening human resources for health, nongovernmental organizations and academic institutions also play a crucial part. There are countries in Africa that have universities that offer health promotion at the degree level. These countries include Benin, Botswana, Ghana, Kenya, Nigeria, Senegal, Sierra Leone, South Africa, Zambia and Zimbabwe. However, post-graduate degrees are very few, and therefore those aspiring to do a Masters or Doctorate in a health promotion-related field end up going to study abroad. Universities in Europe, United States and Asia Pacific (Australia and New Zealand) have been favorite destinations. Lately, we have been seeing students going to Asian countries, notably China, India and Malaysia. Higher degrees are required in order to have local expertise capable of conducting planning, research, monitoring and evaluation in Health Promotion and Social Determinants of Health. With regards to research, monitoring and evaluation, academic institutions and research centers play a significant role in supporting Ministries of Health and other Ministries to gather the evidence required in policy

decision-making or programs. Academic and research institutions collaborate with WHO and other local, regional and international players to support health promotion implementation in Africa. There is growing evidence that supports the efficacy and utility of such collaborations in health promotion, for example the collaboration between the International Union for Health Promotion and Education (IUHPE) and several African countries to address COVID-19, and the WHO Regional Office for Africa with University of Kansas (USA) during the Ebola outbreaks in West Africa.

Health promotion in SDGs: Africa's vision

In February 2015, the newly elected Regional Director of the WHO Regional Office for Africa, Dr Matshidiso Moeti, outlined the Regional priorities (12) as follows:

1. Driving toward equity through Universal Health Coverage;
2. Placing health at the center of development;
3. Accelerating progress on SDGs while tackling emerging threats in health;
4. Strengthening partnership for health; and
5. Building a responsive, effective and results-driven WHO Secretariat in the African Region.

The Transformation Agenda of the WHO in the African Region

The Transformation Agenda (13) is the vehicle for implementing the Vision of the Regional Director of the WHO African Region toward strengthening health systems in order to achieve universal health coverage (UHC) and SDGs. Health Promotion and Social Determinants of Health remains a key part of the Transformation Agenda under the Smart Technical Focus. In this regard, health promotion as a strategy is ideally positioned to address the social, cultural, environmental and economic dimensions of SDG 3. Major lessons have been drawn from previous disease outbreaks such as Ebola and other public health situations, for example HIV/AIDS, noncommunicable diseases (NCDs), neglected tropical diseases (NTDs), maternal and child health and water-borne diseases (12,13). In addressing prevention and control in all health conditions and emergencies, health promotion is an integral part of the response. The Risk Communication and Community Engagement (RCCE) Pillar in all disease outbreaks has its leadership under health promotion, and is recognized as a critical component in preventing, halting or reversing disease outbreak. These are the lessons that are drawn from the Ebola outbreak response in West Africa (14,15).

WHO global conferences on health promotion

A series of global health promotion conferences convened by WHO have made declarations calling for collective efforts to improve the health of populations. As a follow-up to these conferences, the World Health Assembly adopted resolution WHA51.12 on health promotion; resolution WHA57.16 on health promotion and lifestyles; resolution WHA60.24 on health promotion in a globalized world; and the Nairobi Call to Action for closing the implementation gap in health promotion (6,7). In addition, Member States also deliberated on, and endorsed, political declarations with health promotion implications, namely the Rio Political Declaration on Social Determinants and the UN High Level Political Declaration on Noncommunicable Diseases (16,17). The last Global Conference convened was in 2016, held in Shanghai, China. The thematic areas of this Global Conference were (a) good governance; (b) healthy cities; and (c) health literacy and highlighting the importance of governance issues, urbanization and health and empowerment of communities.

COVID-19 in Africa: a situational analysis

The corona virus disease of 2019 (COVID-19) has not spared the African continent from the time it was declared a pandemic. The WHO Africa Region had registered 7,597,420 cases and 159,033 deaths by January 13, 2022 (18). South Africa has the most reported cases (3,546,808) and 92,989 people have died. Other most-affected countries are Morocco, Tunisia, Egypt, Ethiopia and Nigeria. The key intervention strategy in the COVID-19 response continues to evolve around case detection and management, and RCCE and vaccines (19).

The RCCE mandate is to ensure that individuals, households and communities are informed about the

COVID-19 pandemic, and that appropriate measures to interrupt transmission are taken. The WHO guidelines include physical and social distancing, proper use of masks, washing hands regularly with clean water and soap or use of alcohol-based sanitizers, and cough etiquette. The latest frontline intervention is COVID-19 vaccination. According to WHO, in April 2021 about 6.2 million COVID-19 vaccines have been administered in 55 countries across the continent (18). The RCCE Pillar plays a key role in disseminating accurate information regarding the merits of vaccines and dispelling the myths and misconceptions often found in social media. Health promotion now leads the RCCE Pillar and therefore continues to play a significant role in COVID-19 response in the African Region where behavioral, cultural, social, economic and political factors are key in influencing health outcomes (19). The community remains an integral part of implementation of interventions (20). In 2020/2021, IUHPE received funding from Vital Strategies to support RCCE activities in Kenya, South Africa, Zambia and Zimbabwe as part of the COVID-19 response in Africa. This project engaged with key partners to plan and implement a range of RCCE measures, based on health promotion principles, to stop the spread of COVID-19 within local communities. The Kenya and South Africa COVID-19 interventions were implemented in low-income communities, while the Zambia and Zimbabwe COVID-19 activities were undertaken in both rural and urban schools.

Issues and challenges

The African continent is consumed by multiple challenges linked to political, social, cultural, behavioral and economic issues. Significant gaps and challenges still exist in health promotion in Africa. Health promotion needs cadres with new competencies for both policies and strategy management and coordination, including during disease outbreaks linked to emerging and re-emerging disease pathogens, most which have a human-to-animal interface such as Ebola and COVID-19. The other threats to health promotion in Africa remain (a) weak leadership for coordination and stewardship, (b) limited community participation and empowerment, (c) paucity of evidence for policy and strategy, and (d) limited funding for health promotion activities. Furthermore, African countries face a huge burden of disease due in part to poverty, gender inequities, natural disasters, conflicts, climate change and weak health systems. In Africa, the unfinished public health agenda for maternal child health, HIV/AIDS, TB and malaria, and NTDs also require health promotion. A multi-sectoral approach to health promotion is required to ensure that health is a concern of all sectors and not only the Ministry of Health.

Recommendations and conclusion

Health promotion presents a great opportunity for countries to achieve SDG 3 and specifically in managing emerging and re-emerging disease outbreaks, most of which have no known cure. Vaccine-preventable diseases stand to benefit from health promotion practice in terms of improved uptake and reduction of vaccine hesitancy or refusal. In the context of multiple public health challenges including COVID-19, NCDs, UHC and SDGs, it would be prudent for governments, the WHO and partners, and communities to place health promotion high on the development agenda. The following are required actions recommended for governments, WHO, partners and communities in order to see Africa achieve the SDGs and effectively address health emergencies.

1. The role of government

It is prudent that national governments in Africa invest and prioritize:

- Coordination and management – Health Promotion Units should be elevated to a Directorate in countries where this is not the case. This coordination and management role should be supported by availing adequate resources, namely financial, human manpower, time, power and space;
- Implementing innovative financing policy options to ensure that health promotion activities have adequate funding to achieve UHC;
- Use of evidence from health promotion research to inform policies and strategies.

2. The role of WHO and partners

It is recommended that WHO and its partners including IUHPE should focus on:

- Strengthening health promotion capacity for implementation, monitoring, evaluation and documentation within both WHO and Ministries of Health including non-health professionals;
- Establishing norms, standards and strategies for setting up multi-sectoral platforms for integrating Health in All Policies (HiAP), convening of multi-stakeholder dialog, inter-ministerial committees, resource mobilization and citizen forums to promote, support and protect health outcomes across populations and public health conditions;
- Strengthening capacity of Member States to gather evidence for health promotion efficacy and effectiveness, and the application of such evidence into policy making and programs; and
- Advocating for the creation of an enabling environment to support the public to make healthier choices.

3. Community participation

- Participation throughout program development, implementation and evaluation is a pre-requisite for achieving desired outcomes;
- Engagement of community leadership in all aspects of the program to ensure ownership;
- Gender and age equity to achieve parity across population groups.

Conclusion

The state of health promotion in Africa shows great improvement as more countries realize its utility and the gains of having a population that is health literate (4). Health emergencies such as Ebola, cholera, and now COVID-19 have brought health promotion practice high on the agenda of Health Ministers in Africa (15). As social, environmental, economic and political factors deteriorate, inequalities and inequities between and within population groups and countries increase. The number of poor people also rises, leading to high burden of disease and premature deaths. The SDGs are meant to redress the inequities and inequalities between and within countries by closing the gap. Public health conditions, emerging and re-emerging, require that populations respond appropriately and effectively. Health promotion has played its role in the past and continues to do so now even under difficult conditions due in part to shortages of both human and financial resources. Africa is facing multiple challenges in health care delivery, and finds itself with fewer options other than to invest in addressing inequalities and inequities through health promotion. The call for strengthening health promotion policy and practice strategies in Africa continues to grow, especially now in the context of COVID-19. Health promotion remains a wise and justifiable investment.

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ORCID iD

Davison Munodawafa https://orcid.org/0000-0002-1739-1955

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Redefining health promotion to reach the unreached: opportunities for transformative change in South and South-East Asia

Alok Mukhopadhyay[1,2] and Nancepreet Kaur[3]

Abstract: The pandemic has exposed the vulnerability of our civilization and reinforced the importance of living in harmony with nature, not rampaging it in a conquering mode. South and South-East Asia have a vital role to play in achieving the global goal of 'Health for All' as the regions have a significantly large share of global income and multidimensional poor compared to other regions. Clearly, the progress in health and development outcomes of these regions cannot be achieved without addressing social determinants of health and ensuring active public participation. These regions must collectively address the social determinants of health following a realistic health promotion model. It is indeed a favourable time to look beyond the so-called predominantly reductionist biomedical model of health care to a more holistic model of health, that places humans and the environment at the centre, and emphasizes the importance of promoting health and wellbeing.

Keywords: Health promotion, health for all, social determinants of health, health care, sustainable development, South and South East Asia, multidimensional poverty

The regions of South and South-East Asia have a vital role to play in achieving the global goal of 'Health for All'. After all, 24.8% and 8.5% of the world's population resides in South and South-East Asia, respectively (1). Tremendous strides have been made during the last five decades to provide solutions to the problems of health and development within the regions, but these need to be upscaled effectively. The countries in the regions have much in common. Running through them is the thread of a democratic political system. They have given birth to four major religions – Buddhism, Hinduism, Sikhism and Jainism – all of which profess health as one of the main pillars of human enlightenment. This religious underpinning has ensured a well-developed health tradition in the region. Unfortunately, much of this incredibly rich tradition of holistic health has started eroding and it is imperative that sincere efforts be made to preserve and regenerate it before it is too late. The region also has a vibrant and living tradition of volunteerism and has a large body of volunteers and public health networks like the Voluntary Health Association of India (VHAI) (2). Many of them are highly motivated professionals, well equipped to take on the current and future challenges facing the health sector. Unfortunately, critical issues such as centralized planning, inadequate resource allocation, lack of people's involvement and underutilization of the infrastructure remain unaddressed.

On the one hand, given the enormity of this challenge, there is a long way to go. On the other hand, in many countries of South-East Asia, the importance of health promotion is well recognized. For example, Thailand has established a National Health Commission & Assembly in order to enable

1. Voluntary Health Association of India, New Delhi, India.
2. Independent Commission on Development and Health in New Delhi, India.
3. Voluntary Health Association of India, New Delhi, India.

Correspondence to: Alok Mukhopadhyay, Voluntary Health Association of India, B-40, Qutab Institutional Area, New Delhi, 110016, India. Email: alok@vhai.org

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Health in All Policies (HiAP) that encourages participatory healthy public policy development (3). Similarly, Sri Lanka has a National Health Promotion Policy, which is central to the national development agenda, making it a core responsibility of all sectors with the partnership of government, private and non-government organizations and partnerships with civil societies and communities (4). Recently, India has launched the concept of Health & Wellness Centres at the community level to provide comprehensive primary health care (5). Bhutan's Gross Happiness Index, which aims at promoting sustainable happiness and wellbeing, is an important initiative that is worth emulating (6).

South and South-East Asia's health care goals cannot be achieved without addressing the social determinants of health, given the fact that these regions have been accommodating a significantly large share of global income and multidimensional poor compared to other regions. South Asia's share of the global poor has increased from 27.3% to 33.4% during the period of 1990–2013, in comparison to the global poverty rate which has dropped dramatically from 94% (1820) to 10.7% (2013) during the last two centuries (7). We can learn from the Sri Lankan example, where the nation has a low poverty rate compared to other regional members and this is mainly driven by the provision of free education and health services since its independence in 1948. Additionally, Sri Lanka's social protection programmes such as Janasaviya and Samurdhi have also been significant factors in lowering income poverty (8).

It is of the utmost importance when planning and implementing health programmes that efforts are made to tackle some of the key social determinants of health, such as nutrition, drinking water, sanitation and the status of women, among others. While addressing the social determinants of health, a gentle and achievable gradient of change approach needs to be followed, given the polarizing nature of many societies within the regions. The newly established VHAI and International Union for Health Promotion and Education (IUHPE) International Collaboration for South-East Asia will provide a resource centre where global experiences are stored and disseminated within the region. It is also important to encourage collaborative efforts to find evidence-based solutions to new emerging problems in the region.

In this commentary, we consider some of the current opportunities and challenges in advancing health promotion in the region in order to achieve transformative change.

Redefining health promotion in the region

The need for a clear scientific and evidence-based health promotion approach to support the health policy-making process is greater than ever before. Any long-term perspective plan for health promotion has to keep in mind the health priorities of the sustainable development goals (SDGs) (9) and the health reality in the post-COVID-19 world. The current COVID-19 pandemic has exposed the underbelly of our health systems, highlighting the utmost importance of strengthening health promotion efforts in the future. The pandemic has exposed the vulnerability of our civilization and reinforced the importance of living in harmony with nature, not rampaging it in a conquering mode (10).

These regions suffer disproportionately from the high burden of communicable diseases, growing prevalence of noncommunicable diseases (NCDs) and emerging new diseases coupled with widening health inequities and poverty (11). Clearly, progress in health and development outcomes cannot be achieved without addressing social determinants of health and ensuring active public participation.

In these regions, both financial resources and health infrastructure are woefully inadequate. There is a need to examine the financial outlay that is required to meet the unfinished agenda of 'Health for All'. On average, South Asian governments spend less on health, around 0.85% of gross domestic product (GDP), which remains below the global average (5.84%), but there is a great heterogeneity across the region (12). It is evident that a country's economic, social and political stability depends on the investment that it makes in its health care. Health should not be treated as an expenditure, but as an essential investment for sustainable development.

Fortunately, we live in times when health has received its due importance in the global development agenda. Initiatives like the Macroeconomics Commission on Health (13), Global Fund resolve on

TB, Malaria and HIV/AIDS elimination (14), World Bank (15) and considerable investment by private foundations (16,17) in the health sector and in achieving the SDGs are important expressions of this concern. It is critical that post-COVID-19, the quest for better health care will receive a further fillip in terms of sustainable investment. However, a favourable wind is of consequence only if the direction of the boat is right. The great economic forces of the market are now sweeping through the health care system worldwide. Health is a vital human good, and public health systems should play a key role in promoting it. Totally commercializing health care, for the sake of choice and efficiency, runs a potent risk of submitting it to the vagaries of market forces. For instance, the share of out-of-pocket spending is particularly high in Bangladesh (72%) and India (62.6%) (12). This illustrates the burden of health care payments on households in these countries – a consequence of the inadequacy of government provision of health services. Therefore, it is important that the State should remain the principal provider of public health and health care to safeguard it from this risk.

During the pandemic, some citizens across the world resisted simple protective measures like use of masks or maintaining physical distancing. This highlights the fact that health promotion needs to be an integral part of the health agenda for the future, so that communities are empowered to practise healthy living and improve their wellbeing. It is important to learn from the best practices in health promotion around the world and upscale effective approaches. In the process of redefining health promotion, we must rework our communication strategy. In the last few years, the significant presence of social and digital media has captured all spheres of our life. Health information, education and communication strategies need to fully utilize the vibrant platform of digital media to reach out effectively to local communities.

Embedding health promotion into the fabric of all government programmes

We must understand that health is an outcome of all policies. The pandemic brought to light the importance of the slogan 'All for Health'. At the end of the day, not only the health professionals but all of society including local communities, police administration and a range of other sectors had to work collectively to combat the spread of COVID-19. Unfortunately, the non-health sectors in most countries are not trained in the basics of health protection and promotion. We need to ensure that in-service training is provided to all cadres of government and non-government organizations in the basics of promoting population health and wellbeing.

The conditions which influence the health and wellbeing of citizens are largely determined in sectors other than health. Sustainable change can be achieved only if the health sector and related sectors act in harmony. Cross-sectoral partnerships have to be taken into account in the planning stage of health promotion programmes and policies. The health sector can play a catalytic role and facilitate coordination of action that is intersectoral and community-based.

The COVID-19 crisis exposed the fact that the benefits of globalization do not come into active play when such disasters strike. In future, we need to develop a mechanism for horizontal integration of responses to such a crisis of global proportion. IUHPE has a significant role to play by ensuring that the existing knowledge and tools of health promotion are shared globally with key stakeholders and simultaneously working with them to find solutions to new and emerging problems. For example, IUHPE and VHAI have collaborated on COVID-19 prevention and management to build healthy and resilient communities in the remote parts of India. Using risk communication and community engagement strategies, the approach focuses on strengthening the capacity of the local stakeholders/health promoters and health systems for community-based health promotion.

Evolving a realistic health promotion roadmap for the disadvantaged

A few years back, the World Health Organization (WHO) took the initiative to highlight the importance of addressing the social determinants of health (18) but not much action followed. The pandemic showed how more than one-third of the global population, living in urban slums without proper infrastructure, have hardly any chance to protect themselves from the spread of communicable diseases or a pandemic. The impact of the pandemic across many urban centres showed how little has

been done to improve the living conditions of the socially and economically disadvantaged. The crisis highlighted the vulnerability of people working in the unorganized sector. They lost their livelihood overnight due to sudden lockdown and had to undertake long inhumane journeys back to their native places. It is imperative that we systematically address the challenges of the social determinants of health to ensure the health and development of the entire population.

We are yet to evolve a realistic health promotion roadmap for people living in economic and social deprivation. Current health promotion strategies largely cater to the needs of the developed countries. However, as per the Global Multidimensional Poverty Index 2020 report released by the United Nations Development Programme (UNDP), 22% of the population, across 107 developing countries, live in multidimensional poverty (19), where they are not able to meet their basic food requirements and do not have access to basic facilities like safe drinking water and sanitation. Recommending expensive dietary options to those who cannot afford to have even one full meal a day is being insensitive to the realities of socio-economically deprived people. However, encouraging people to consume traditional foods that are locally available and affordable would meet their nutritional needs. Our present health promotion approach for disadvantaged groups may sound like Queen Marie Antoinette's answer to the hungry crowd asking for bread: 'If you do not have bread, eat cake!' (20). We have not been able to evolve a clear implementation strategy to address the social determinants of health, in spite of the clear recommendations of Bangkok Charter on Health Promotion in a Globalized World (21).

Governments need to ensure that healthy food options are affordable and accessible to people living in economically deprived communities. There is a need to strengthen sustainable efforts to uplift those living in poverty from their current state by increasing their minimum wages, improving accessibility to health services and ensuring access to good living conditions including clean water and proper sanitation.

Way forward

A healthy nation is the sum total of the health of its citizens, communities and the settlements in which they live. Therefore, it is crucial that there is full citizen participation in efforts to achieve the goal of 'Health for All'. It is indeed a favourable time to look beyond the so-called predominantly reductionist biomedical model of health care to a more holistic model of health, that places humans and the environment at the centre, and emphasizes the importance of promoting health and wellbeing. With seven decades of successful evidence-based work in numerous settings across the world, IUHPE is well placed to play a vital role in advancing health promotion in the regions, working in collaboration with local partners to ensure that this much neglected but essential aspect of health is implemented effectively.

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ORCID iD

Alok Mukhopadhyay https://orcid.org/0000-0002-1329-5632

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The International Union for Health Promotion and Education 1987–2001: health promotion experiences, reflections and possible lessons

Spencer Hagard

Introduction

Having had the great honour of serving as its president from 1996 to 2001, I congratulate the International Union for Health Promotion and Education (IUHPE) on reaching its 70th anniversary. I am honoured to be invited to contribute to this special issue of *Global Health Promotion*.

I shall reflect on some experiences in the period from 1987, when I joined the Board of Trustees, to 2001, at the end of my term as president, and then link key features of those experiences to the evolution of the IUHPE's role in the development of global health promotion, and finally suggest possible lessons for the future.

Experiences

Discovering the Union

Despite a prior decade of responsibility for the health education team in my local health district, and despite the 1979 IUHE 10th World Conference in London having taken place only an hour's train ride away, I had not previously heard of the International Union for Health Education (IUHE), as it was known at the time, when I first encountered it in 1987, following a career move from local public health practice to a national health promotion institution, and straight into its automatic place on the Board of Trustees.

Challenged by health promotion

At that point, IUHE was faced with the newly fledged health promotion movement, driven by the European Office of the World Health Organization (WHO), and which the IUHE Board recognised as aiming to transcend lifestyles education through more holistic, scientifically based and political approaches to health, demanding new theoretical understandings, innovative evaluation methods and new practical skills in many new settings.

While IUHE Board members – institutional and individual – largely welcomed the WHO initiative, they were divided and undecided on what it meant for the Union. Almost all were primarily engaged in lifestyles health education practice, teaching or research; many institutional members were limited to health education by statute or charter: some questioned the practical feasibility of IUHE embracing health promotion; concerns were widely expressed that health promotion's political dimension risked the withdrawal of IUHE's main funders, namely government-sponsored institutional members.

Years of argument within IUHE, often passionate, followed. As it dragged on, health promotion leaders within WHO became impatient, and dismissive of IUHE. At the same time, internal divisions within WHO, with which the Union was and remains in official relationship, did not contribute to early resolution by IUHE. In 1993, health promotion was finally embraced, the name was changed to IUHPE and the Union was released to seek its path in health promotion, by then a greatly expanded field, with many new organisational actors.

Disinvestment and re-orientation

The early 1980s brought a harsh (and still continuing) policy climate, in which publicly funded bodies and 'not for profit' organisations fell from favour and became casualties of disinvestment by many governments. However, until the mid-1990s, probably because of the HIV/AIDS pandemic, health

Past President, IUHPE.

Correspondence to: Spencer Hagard, 398, CB4 1SU, UK. Email: spencer.hagard@gmail.com

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promotion practice, research and teaching were to some extent spared, though erratically, and often with short-term funding to fragile, ad hoc bodies with limited health promotion skills. From the mid-1990s, effective HIV treatments emerged, and organised health promotion faced substantial disinvestment by many governments and their agencies. The consequential impact on IUHPE, through severe limitation or disappearance of some substantial, long-term funding sources, seriously threatened its financial survival.

As a result, the task of sustaining core IUHPE administrative, scientific and professional functions increasingly relied on project funding, which carried the risk of substantial diversion from IUHPE values and mission becoming the cost of survival. That this calamity was avoided owes much to the skill, courage and work ethos of IUHPE's tiny group of employees, and to the willing donation of their time and skills by many members.

The Union was thus able to engage successfully in a series of externally funded projects, which were all central to its mission and to the wider development of health promotion, including: the evidence for the effectiveness of health promotion; the infrastructures needed for effective health promotion practice; and core competencies needed to practise health promotion. These were not only instrumental in immediate survival, but helped the IUHPE begin to find its place in the longer-term development of health promotion: identifying and building on its strengths, learning from failures, identifying creative opportunities to work collaboratively with others, and becoming smarter about threats to its global and regional roles, including from among competitive allies!

Reflections

In April 2019, I was fortunate to be able to attend the IUHPE 23rd World Conference on Health Promotion. Like its predecessors, this fine conference provided a stimulating gathering of the IUHPE's 'international network that encourages the free exchange of ideas, knowledge and experiences, collaborating in the development and implementation of projects at global, regional and local levels' (1). Conference sessions were enhanced by many distinguished contributors, both local and global, from outside and within IUHPE membership.

The conference was held in Rotorua, New Zealand, and entitled 'WAIORA: Promoting Planetary Health and Sustainable Development for All'. A year later, in April 2020, early in the COVID-19 pandemic, I was surely not alone among the conference attendees to reflect on the prescience of its title?

Throughout a further 18 months to November 2021, as the pandemic has raged, with planetary health increasingly damaged and sustainable development hugely set back, the values and practical skills of health promotion – which could have contributed greatly to limiting this global disaster – have gone largely unmentioned and not applied.

For me, this has brought vividly to mind IUHE's limited reach in the 1980s; its struggle to embrace health promotion; the greater role and impact that health promotion might have built against HIV/AIDS in the 1980s–1990s; and IUHPE's financial precariousness and manner of survival in the 1990s and 2000s. And this has stimulated thoughts of possible lessons for the future.

Possible lessons

With ever greater expected threats to the global environment and to health and wellbeing, organised health promotion can provide cost-effective counter measures.

I suggest that IUHPE – as the only experienced and effective global organisation wholly devoted to health promotion – should consider giving high priority to:

1. Multiplying the power and reach of its advocacy to relevant decision makers, at all key levels in all societies, arguing the case to them for developing and sustaining effective health promotion.
2. Building IUHPE global membership, to be far larger in breadth and depth, and enabling and encouraging members to become effective advocates for health promotion's ability to enhance human health and wellbeing, and for the local infrastructures and resources it requires.
3. Initiating IUHPE engagement at top national political levels, reaching out first among the handful of heads of government and top

administrators, whose responses to COVID-19 indicate that their values, approaches and skills might encourage them to consider helping to create top level active alliances among nations for the advancement of global health promotion.

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The 70th anniversary of the International Union for Health Promotion and Education: reflections on advancing our social justice mission

Maurice B. Mittelmark

My 'baptism' into the International Union for Health Promotion and Education (IUHPE) happened at the 1998 IUHPE World Conference in Puerto Rico.

This was my first IUHPE conference, and it enthralled me! After years of participating in comparatively staid public health conferences, I experienced Puerto Rico as a cauldron – boiling, not simmering! – of social justice debate. I became instantly and wholly absorbed by the fantastic people, the mission and the action style of the IUHPE, and the leaders' and members' fiery engagement for health equity. I was not the only one infected by the Puerto Rico 'bug'; ask others who were there; I feel confident many will back me up ... Puerto Rico was health promotion's Woodstock!

Having been invited to write this anniversary commentary, and still inspired by the spirit of Puerto Rico, my reflections today – 23 years later – turn to this: In our hearts, we who have joined the fellowship of the IUHPE are social activists. We faithfully carry on our daily duties in health promotion teaching, research, and practice, and we are passionate about accelerating health equity. But our daily duties are distracting. How can our passion for justice be ignited to a brighter flame? What actions might we take to propel us further in our quest to advance health equity?

We indeed have the stamina – the extra energy – to tackle challenging questions like these because we have done well in setting the groundwork. We have undoubtedly advanced health promotion as a profession. We have learned how to work well together to achieve challenging goals. Just look to our achievements. We undertake vital health promotion professional activities that no other organisation tackles. We establish professional standards for health promotion in higher education, and we enhance health promotion's effectiveness. We monitor progress, we undertake theory development and we work to advance professional practice. Since 1951, we have presented and represented health promotion and education right across the globe (see https://www.iuhpe.org/index.php/en/iuhpe-world-conferences-on-health-promotion for a list of the 24 IUHPE global conferences held since 1951).

But what about our future? My proposal: we should strive even more forcefully to retain and strengthen our commitment to health equity; we should reignite the spirit of Puerto Rico! Let us recommit to social justice as the front and centre value that makes the IUHPE fundamentally different from other health and education professional and disciplinary organisations. Let the IUHPE be our unique source of social justice nourishment, quenching our thirst for further health equity.

Am I calling for us to revive a dormant part of ourselves? Certainly not!

In the decades since Puerto Rico, the IUHPE's propensity for social action has been evident in many projects and publications on the effectiveness of health promotion, on the training and accreditation of health promoters, on fostering quality and innovation in health promotion research, on health promotion in community settings and in advocacy directed at the World Health Organization (WHO), the European Commission and many other national and international governmental and non-governmental organisations.

But can we do even better? Certainly! Social justice is our beating heart, but it could beat more vigorously!

The vision of the IUHPE is a world where all people achieve optimum health and wellbeing. Inequalities in health status are increasing in accordance with

University of Bergen, Bergen, Norway.

Correspondence to: Maurice B. Mittelmark, University of Bergen, Bergen, 5007, Norway.
Email: maurice.mittelmark@gmail.com

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increasing inequalities in socio-economic status. The IUHPE can make a significant contribution to advocacy and action to redress the growing imbalance in the distribution of the world's resources between high-income and low- and middle-income countries, as well as among different population groups. The burden of poor health continues to fall disproportionately on lower income countries and the most vulnerable populations. The resulting social and economic insecurity is rapidly translating into an increasing gap between rich and poor within all countries in access to and application of the resources necessary for health.

There is no question about it: our ambition is to be a *professional community for social justice* (1–4). Not a professional community for tobacco control, healthy diets, physical activity, mental health, health in schools and workplaces, health literacy or salutogenesis. These are among the many health promotion and health education arenas wherein we do research, teach and practice. There are many societies and professional groups that serve these interests. Most of us are affiliated with at least one such disciplinary/professional organisation. Our unique contribution is to pursue not only health improvement but also health equity.

The IUHPE is a mixing pot of professionals with wide-ranging duties and responsibilities, yet we are more: we aim to be champions on a global level for health equity.

To further develop this unique aspect of the IUHPE's persona, we should consider actions like these:

- In our journal and at our conferences, we might establish explicit and highly visual activities that concentrate our attention on our mission:
  - Inequalities in health are increasing; let this problem be the focal point of our education, practice, policy and research priorities.
  - There is a growing imbalance in the distribution of the world's resources; let us produce and disseminate knowledge on how the fairer distribution of generalised and specific resistance resources could help people, communities and nations achieve health equity.
  - The burden of poor health falls on lower-income countries and the most vulnerable populations; let us illuminate this inequity with regular trend analyses/reports released to public media.
  - Justice for human health is inextricably intertwined with justice for Gaia – our wonderful but severely stressed planet. Let us advance global health and health for the globe.
- We have had as long-term partners health organisations such as the WHO, the European Public Health Association (EUPHA), the American Centers for Disease Control and Prevention (CDC), the UK Department for International Development (DFID; now part of the Foreign, Commonwealth and Development Office), etc. Well and good, but not sufficient! Let us also seek out and develop strategic collaborations with global, national and local organisations devoted to these social justice causes:
  - Civil rights and legal defence
  - Immigration rights
  - Criminal justice reform
  - Disability rights
  - Elder, children and family advocacy
  - Women's liberation
  - Gay, lesbian, bisexual and transgender liberation
  - Family planning

Yes, let us be even more brazenly political; let us take up common cause with like-minded social justice groups and movements. Let us look, feel, smell, taste and act like what we aspire to be, a professional community for social justice.

Let us be bold! Years ago, IUHPE members audaciously modified our organisation's name to include 'health promotion' – do newer members even *know* that we were once the International Union for Health Education?

Time, again, to be bold? The International Union for Health Equity?

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Statement on the 70th anniversary of the International Union for Health Promotion and Education

David V. McQueen

Congratulations to the International Union for Health Promotion and Education (IUHPE) on 70 years of service to the health promotion community! Let me personally attest to the gratification it was to serve as Vice-President for Scientific Affairs (2004–2007; 2013–2016) and President of IUHPE (2007–2010). In particular I enjoyed working over many years with the competent and wonderful staff based in Paris. In addition, it was a real pleasure to work with many of the dedicated individual members of IUHPE. Memories of that time linger and remain as a highlight of a 50-year career in public health. Many of those I worked with at IUHPE remain close friends to this day.

It has not always been easy for a non-governmental organization (NGO) in health promotion. Global health promotion itself has had a long and tortuous path in the public health arena. It has always had an uphill struggle to be seen as a critical component of public health by the established public health profession, somewhat analogous to how public health has been regarded as a secondary choice in medicine. Make no mistake, health promotion has been and remains a marginalized field of public health. The he extent to which this unfortunate situation has improved over the years can be attributed to IUHPE and other NGOs motivated by a determination to change public health to a social science-based field addressing the health of the public. Causality is a difficult concept, but I have little doubt that such key ideas as concern with the health of marginalized peoples, concern with health as an area of policy and advocacy in sectors outside the biomedical sector, and a general concern with those socio-economic factors that underlie the health of the public significantly emerged from the work of IUHPE and other key global health organizations. Of course, direct evidence of such an organizational impact is not easily proven, but the continuing and persistent efforts of IUHPE, its officials, its staff and its members to emphasize a broader concept of public health is revealed in its 70 years of work. Furthermore, IUHPE is particularly challenged due to its global emphasis, because global membership-based organizations have special financial challenges to sustain their influence and viability. Nonetheless, the organization has survived and continues to work at the global level.

Predicting the future of IUHPE, or public health for that matter, may be a fool's errand. Nonetheless, over many years IUHPE managed to keep its emphasis on the broad global goals of health promotion. Current times appear to be a challenge to this mission especially as we witness a rising anti-globalism and return to crass nationalism. Hopefully, the long-term trend will be in the direction of IUHPE's global interests. In fact, the pandemic of 2020 has revealed with great clarity the necessity and key role of global health promotion in the future of the public's health. The helplessness of clinical medicine to address the pandemic was revelatory. Further, across much of the globe and most notably in the world's most advanced economies, traditional public health was found wanting in dealing with the pandemic. What was revealed was the role of health literacy, politics, policy, confusion, complexity, communication, racism and prejudice in the pandemic – all areas that are profoundly at the center of health promotion's remit and relate to the discourse on what promoting the public's health is really about. In other words, the need for work that is basic to IUHPE's global mission was revealed. The challenge for an organization like IUHPE is to continually address the fundamental issues that drive health promotion as a concept and to convey the message of health promotion to the public at large, but most importantly to the field of public health. The field and practice of public health exist

Universität Bern, Bern, Switzerland.

Correspondence to: David V. McQueen, Universität Bern, Bern, Switzerland. Office Address, 2418 Midvale Ct, Tucker, GA 300084, USA. Email: dvmcqueengc@comcast.net

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particularly in institutions: schools of public health, government departments of public health, and global organizations of public health. A survey of most of these institutions across the globe would reveal, in my opinion, a paucity of the health concerns shared by IUHPE and many other health-related NGOs. For the future of IUHPE and health promotion, this must change and IUHPE should play a significant role in addressing this needed change. For example, for at least the past 150 years we have known the role of poverty in fostering poor health in the public sphere. This role is not well addressed by traditional epidemiology, despite good efforts by many practitioners to develop a meaningful social epidemiology, and yet epidemiology with its bio-medical base is still seen by many as the 'science' of public health. The 'science' of public health is not really found in the biomedical sciences, it is in the social sciences. It is the challenge of organizations like IUHPE to make this point, over and over, until the public's health changes.

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Reflections on the International Union for Health Promotion and Education

Michael Sparks OAM

It is a great privilege to be able to reflect upon the contribution of the International Union for Health Promotion and Education (IUHPE) since its foundation in 1951 and into the future. The IUHPE is one of those rare organizations that brings together expertise from scientific researchers, on-the-ground practitioners, policy makers, academics and students. We have a distinguished and successful history of synthesizing theory and research into effective and context-specific training for practice and education. The IUHPE has long recognized the two-way traffic on the bridge between practice and research, giving due status and respect to those in, and studying to be in, both fields. We further work with academic institutions and governments to develop standards and accreditation for health promotion that ensure a well-trained workforce for translating knowledge into practice. Our stable of publications serves to disseminate knowledge, information, research and practice methodologies to a broad range of health promotion and education practitioners in a range of languages. Our regional and global conferences provide opportunities for sharing knowledge, challenging thinking, and networking among our organizational and individual members. Our close links and associations with international networks provide strength to our knowledge-base and assist us as we collaborate to deliver effective outcomes. We have earned a reputation as being respected advisors as well as developing internal capacity to conduct research, provide information, develop and administer programs and bring together internationally respected players to solve problems.

In my 15 years on the Executive Board, I witnessed the strength and resilience of the organization as we changed our governance structures, developed an international accreditation system and developed an international secretariat in Canada. I personally witnessed the strength of the membership through participation in conferences, journals, regional structures, the global board activities and through countless IUHPE activities. Over the past seven decades the IUHPE has proven to be adaptable and has become more agile, in line with the demands of the fast-changing world. For example, we have addressed the challenges presented by the COVID-19 pandemic through our projects, dissemination of knowledge and information through Global Health Promotion and IUHPE-associated journals, webinars and communication media. Our efforts through the People-Planet-Health initiative are assisting grassroots environmental and health promotion groups to combine efforts, knowledge and strategies to target planetary and population health. I believe these issues will come even further to the fore in the near future and the IUHPE has already proven that it can put structures in place to advance this important global health issue.

When I reflect upon my time as an active member of the Board, my thoughts linger on the people that the IUHPE brings together, and the opportunities it presents for discussion of problems, development of solutions and identification of research priorities. I think back on the dynamic and inspiring conferences, the opportunities to meet the greats of health promotion and the chances to engage in constructive dialogue with colleagues from all parts of the world. While the structures and communications media of the IUHPE work well and serve the global health promotion community to an exceedingly high standard, it is the people that linger strongest in my thoughts. I have never ceased to be amazed by the staff of the IUHPE. From the executive director to the heads of sections, project staff to administrators, the IUHPE knows how to choose the best people for its needs. The professionalism, high standards and excellence that each of these staff members embodies

Past President, IUHPE.

Correspondence to: Michael Sparks OAM, IUHPE, c/o École de Santé Publique, Université de Montréal, 7101 avenue du Parc, Montreal, QC H3N 1X9, Canada. Email: msparks@homemail.com.au

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is inspiring. One could say that the IUHPE has been lucky in its staffing, but I think the greatness of our staff reflects much about the people in the organization, what they stand for and what they look for in staff. The diversity and energy of our international board membership is another strength for the organization. We manage to bring together people from culturally and linguistically diverse backgrounds, and from countries and parts of countries of all economic positions. In all its endeavors the IUHPE strives to respect people and cultures. We know that to work effectively we must work with communities rather than *on* them or *for* them. Getting to know people and learning how to most effectively achieve results with them is the forte of the IUHPE. Bringing together the best researchers, practitioners and students and exposing them to challenging ideas and global best practices and connecting them to other networks of like-minded thinkers is what we do best. I have every confidence that our past will be reflected in our future and that we will continue to thrive as an organization because of our ability to do these things.

If I were pressed to present my thoughts on where the IUHPE should concentrate efforts in the future, I would firstly indicate that I think we are doing an exceptional job at keeping our finger on the pulse of global activities and maintaining a focus on the most relevant issues. That said, I believe that the health impact of climate change will grow in focus once the current pandemic is controlled. The existing work that the IUHPE does on climate change may expand and be more globally inclusive. This topic has always been difficult due to the strength of political and financial vested interests in some areas, but the IUHPE has proven repeatedly that it can be a conduit to work towards solutions. We certainly won't resolve the issues on our own, but I believe we can make a stronger contribution to this vexing global problem.

In conclusion, I will add my gratitude to the staff, IUHPE members and fellow members of the governance structures whom I have had the privilege to work with over the past 20 years. Working with such supportive and talented people gave me joy in my life and left me with a sense of accomplishment in what we did. I am so proud and happy to have been a part of the IUHPE, a wonderful organization that does great work and has had a profound effect on the health of the planet.

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The IUHPE: 70 years young, but what's in a date?

Graham Robertson[1,2]

According to the English poet Philip Larkin, 'Sexual intercourse began/In nineteen sixty-three' (Annus Mirabilis), reflecting a particular period in British history, which might also explain why for many years the term health education was equated with sex education in the UK! In the same generational way, it can sometimes feel as if health promotion only began with the publication of the Ottawa Charter in 1986. Historians of different periods and cultures would likely make the case that it has been around for much longer than that. But the creation of the International Union for Health Promotion and Education (IUHPE) in 1951 marked a significant milestone in the evolution of the field as it started to become codified and associated with a set of professional skills and knowledge.

The IUHPE's purpose 'to influence and facilitate the development of health promotion knowledge, strategies and projects' is achieved through evidence-informed advocacy work, partnerships and creating opportunities for shared learning. Each of the previous 23 IUHPE World Conferences has progressed our organisation's vision of 'a world where all people achieve optimum health and well-being'. But there is still much to be done. A former colleague argued the case that, if successful, there should be less need in the future for specific health promotion-labelled action as it would have been mainstreamed: if all settings were intrinsically health-promoting, if all sectors routinely collaborated towards a shared goal of improved health then the job would be done. I think the argument was made to emphasise the need for a genuine move towards what we would now call a Health in All Policies approach.

However, in the real world, despite the positive rhetoric, we are not at that stage. The IUHPE and its members still have much to do. Adopting the consultant's toolkit approach of encouraging organisations to think about what they should continue to do, stop, start or do more of, here are some reflections on a future agenda for the IUHPE.

The structure of the IUHPE as a global body with regional components epitomises one of its main strengths: we are able to provide a worldwide perspective on health promotion whilst allowing for some more regionalised and cultural adaptation. The challenges the world is currently facing serve only to emphasise how important this is. The sharing of knowledge widely and freely without political interference is critical to effective action in health promotion.

Of course, it is not just knowledge that is important. So too is the technical expertise and capacity to implement. These are central to tackling the implementation gap. The work that the IUHPE has led on health promotion competencies and its related Accreditation System (https://www.iuhpe.org/index.php/en/the-accreditation-system) will play a vital role in helping to address this issue. Having a quality-assured competent workforce will do much to create the capacity needed and strengthen the influence of health promoters. And in a world in which so-called influencers set themselves up to advise and pontificate on all manner of things, including health, putting in place a system for accrediting the work that we do becomes even more essential.

In our Executive Board's Work Plan 2016–19, and in recent promotional material, we have stated our intention 'to be seen and heard as the international voice of health promotion, which means being a vibrant and relevant organisation that adds value to our members and partners'. To effect, that relies on several characteristics: first, that we have noteworthy and important things to say; secondly, that we do indeed give voice to our views, utilising a variety of platforms. A cursory glance at the Advocacy page on the IUHPE's website reveals a strong body of Official

1. Immediate Past President, IUHPE, Montreal, Quebec, Canada.
2. School of Public Health (ESPUM), University of Montreal, Montreal, Canada.

Correspondence to: Graham Robertson, International Union for Health Promotion and Education: c/o École de Santé Publique, Université de Montréal, 7101 avenue du Parc, Montreal, QC H3N 1X9, Canada. Email: grahamrconsulting@gmail.com

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Statements. Of course, the crucial task is to be on the lookout for emerging issues that warrant comment as well as ensuring that existing positions are reinforced and/or updated. I believe that our role in evidence-informed advocacy will remain a significant one based on our ability to acquire, collate, and communicate knowledge effectively, and as a trusted source.

One area in which the IUHPE must still be active in advocacy terms is in the level of investment in public health generally, and health promotion specifically. The Organisation for Economic Co-operation and Development's (OECD) *Focus on Health Spending* report (2015) and its Working Paper *How much do OECD countries spend on prevention?* (2017) reveal a worrying trend. Both reports document a decline in expenditure on public health in 'around half of OECD countries since 2009'. The latter paper comments that while only a fraction of health spending already goes towards prevention, 'spending on prevention was particularly affected following the economic crisis' of 2008. Given the COVID-19 pandemic events of 2020, the authors' somewhat prescient comment that while acknowledging the public health challenges of noncommunicable diseases (NCDs), 'at the same time, the threat from infectious diseases, both old and new, require health systems to be alert and responsive'. No doubt the financial accounts of public health expenditure for 2020 and 2021 – the IUHPE's anniversary year – will show a large increase for obvious reasons. But the resilience of the system overall and the potential for health promotion to make a difference depend on realistic and sustainable levels of funding.

All of which brings me to the work the IUHPE has been doing on describing and making the case for a properly designed and positioned Health Promotion System. The 10 system requirements articulated in the IUHPE's position statement (https://www.iuhpe.org/images/IUHPE/Advocacy/IUHPE_NCDs_positionstatement.pdf), originally prepared for the United Nations' high-level meeting on NCDs in 2018, provide a cogent case for what an effective system would look like and why it would be beneficial. We are now 72 years on from the establishment of the World Health Organization, and it is 70 years since the creation of the IUHPE and yet, of how many member states could we confidently say that they come close to meeting those 10 requirements? Not many I would guess; certainly not enough.

Let us hope that it will take fewer than 70 more years to reach our goals, but I remain confident in the belief that the IUHPE has a major role to play in achieving them.

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Préface

« Un regard sur l'avenir de la promotion de la santé : apprendre du passé, façonner l'avenir »

Liane Comeau[1] et Marie-Claude Lamarre[2]

> « Une commémoration ne constitue pas un point d'arrivée : elle ne peut être qu'une pause incitant à une réflexion constructive et mêlant dans une même dynamique un bilan tourné vers l'avenir avec une prospective enracinée dans le passé. » (1)

Quand on fête un anniversaire, on célèbre une date, celle d'une naissance, d'une fondation, d'un mariage, d'une mort. Il s'agit bien d'un point d'ancrage et de repère dans le temps qui se réfère à une personne, à une institution ou à un évènement, à la continuité d'une histoire et qui rassemble. Il est question ici de célébrer l'avènement d'une institution qui compte dans une communauté et dans notre monde.

Nous fêtons cette année les 70 ans de la création à Paris, en mai 1951, de l'Union internationale de Promotion de la Santé et d'Education pour la Santé (UIPES). Il s'agit d'un moment exceptionnel pour réaffirmer notre engagement pour un monde plus équitable et pour poser un regard optimiste sur l'avenir de la promotion de la santé. Nous célébrons des valeurs, des principes – principalement la justice sociale et l'équité, la diversité, le pouvoir d'agir sur sa propre santé et sur celle de sa communauté, le travail en partenariat – qui nous réunissent en promotion de la santé et qui font que nous nous reconnaissons dans un espace de santé publique de plus en plus enchevêtré de concepts, de théories plus ou moins consensuelles, de pratiques.

Nous célébrons la contribution unique de la promotion de la santé comme une réponse aux défis de nos sociétés, à quelque niveau que nous soyons – local, régional, national ou international, dans le respect et la complémentarité des rôles et missions respectifs dans les milieux politiques, académiques et pratiques. Le travail entre les secteurs en faveur de la santé et du bien-être, par ailleurs semble de plus en plus pertinent dans un monde complexe où la santé est tributaire de facteurs multiples.

Cette édition de *Global Health Promotion*, la qualité des contenus qui composent ce numéro spécial, est un très beau cadeau d'anniversaire offert à l'UIPES, à ses membres et aux lecteurs de la Revue. En associant les points de vue de plusieurs générations de penseurs, chercheurs et praticiens, c'est un peu comme une « réunion de famille », celle des membres et partenaires proches de l'histoire et de l'évolution de l'UIPES, qui rassemble des leaders et des visionnaires de la promotion de la santé qui l'ont beaucoup servie, et des représentants des nouvelles générations. Ce numéro spécial propose une réflexion sur les manières de poursuivre l'avancement de la promotion de la santé, à travers le monde, sur les plans de la recherche, de la pratique, et du développement des politiques publiques.

Comme nous le savons tous, il n'existe pas une conception unique et universelle de la promotion de la santé mais une conception plurielle qui s'inscrit dans une histoire de la santé publique, dans des conditions politiques, culturelles, sociales et économiques locales et dans des systèmes. Ce qui crée le lien entre ces visions c'est que l'on s'accorde à aborder la santé comme une entreprise sociale à travers un ensemble de stratégies menées conjointement pour atteindre un même objectif incluant le plaidoyer, l'éducation, la formation, la recherche, la législation, la coordination des politiques et le développement communautaire, quels que soient les problèmes à résoudre, les populations concernées ou les contextes et milieux de vie.

Un autre lien commun est celui de cibler les multiples déterminants de la santé et d'associer la réalisation de la santé à des ajustements structurels apportés par des changements politiques, économi-

1. Directrice Exécutive de l'UIPES, Montréal, Québec, Canada.
2. Ancienne Directrice Exécutive de l'UIPES, Paris, Saint-Maurice, France.

Correspondance à : Liane Comeau, Directrice Exécutive de l'UIPES, c/o École de Santé Publique, Université de Montréal, 7101, avenue du Parc, Montréal, Québec H3N 1X9, Canada. Email : lcomeau@iuhpe.org

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ques, environnementaux et sociaux. À ce propos, le discours actuel sur les changements climatiques et leurs répercussions sur les populations, ainsi que les Objectifs du Développement Durable de l'ONU, offrent des ancrages pour agir sur l'ensemble des déterminants de la santé de manière coordonnée et systémique. La pandémie de COVID-19 que nous vivons actuellement met également en relief les failles de nos sociétés et souligne l'importance d'approches systémiques pour réduire les écarts pour favoriser la santé et le bien-être de tous.

Nous célébrons donc 70 années de participation et d'apprentissage, de réflexion partagée sur le rôle et le sens de la santé et de la promotion de la santé dans nos sociétés contemporaines, d'innovation, de tâtonnements et d'accomplissements. Il n'y a aucun doute cependant quant à la pertinence de ce domaine, de ses approches et de ses méthodes pour relever les enjeux du présent et du futur.

Nous célébrons 70 années de collaborations, de relations qui nous survivent par la transmission et la diffusion des idées, des savoirs et des expériences et notre complémentarité est un gage d'efficacité dans la poursuite de nos objectifs communs. Faire partie de l'Union internationale de Promotion de la Santé et d'Education pour la Santé, c'est faire partie d'une communauté engagée. Participer à ses projets, à ses évènements, à son rayonnement, c'est avoir le privilège de côtoyer les meilleurs, d'échanger, et d'apprendre à leurs côtés. L'UIPES n'a d'existence et de richesse que par celle de ses membres, que par sa diversité de connaissances et de pratiques accumulées au fil des ans. Cette communauté globale d'individus et d'institutions est ouverte, inclusive, et accueille de nouveaux membres en continu.

Ce numéro spécial de *Global Health Promotion* mesure le chemin parcouru et relève également des enjeux majeurs de la promotion de la santé qui continuent à susciter de nombreux débats : la valorisation et la reconnaissance de notre domaine et champ d'action, son inscription dans une culture, la complexité de l'organisation de la promotion de la santé dans le cadre politique et dans une perspective systémique, ainsi que le besoin de formation à tous les niveaux, afin de concilier le discours et les actions et de bâtir de nouvelles générations d'acteurs qualifiés, compétents et motivés.

Puisse cet ouvrage contribuer à ouvrir la voie à de nouvelles perspectives et projets de société fondés sur des données probantes accumulées partout dans le monde au fil des ans !

Référence

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Un regard sur l'avenir de la promotion de la santé : apprendre du passé, façonner l'avenir

Margaret M. Barry

C'est un honneur pour moi d'être la rédactrice invitée de ce numéro spécialement publié à l'occasion du 70ème anniversaire de la fondation de l'Union internationale de Promotion de la Santé et d'Éducation pour la Santé (UIPES). Ce numéro offre une occasion toute particulière de réfléchir de manière critique à l'évolution et au développement de la promotion de la santé et d'examiner le rôle joué par l'UIPES dans l'avancement de ce domaine maintenant et à l'avenir.

L' « Union internationale d'Éducation sanitaire » a été officiellement lancée en 1951. Cette organisation internationale non-gouvernementale a été fondée par le professeur Jacques Parisot, Professeur de Santé publique à l'École de Médecine de Nancy, en France, et M. Lucien Viborel, Directeur du Centre national d'Éducation sanitaire, démographique et sociale du Ministère de la Santé en France. Le gouvernement français a quant à lui promu l'organisation de l'Assemblée constitutive de l'Union en mai 1951 lors d'une conférence internationale à Paris. C'était une période de grands changements au lendemain de la Seconde Guerre mondiale, qui a mis en évidence le besoin urgent d'une coopération mondiale. Les Nations Unies ont été fondées en 1945, incluant la création de l'Organisation mondiale de la Santé en tant qu'agence spécialisée, responsable de la santé publique internationale dans le but de promouvoir et de protéger la santé de tous les peuples. La création de l'Union internationale quelques années plus tard a été un développement stratégique à long terme, avec la prise de conscience qu'un mouvement mondial de personnes et d'organisations engagées dans la promotion de la santé de la population était nécessaire pour accompagner la vision et les travaux des agences internationales telles que l'Organisation mondiale de la Santé. Au cours des 70 dernières années, l'Union internationale a grandi et a développé sa mission principale, en embrassant la Promotion de la Santé y compris dans son titre en 1993 pour devenir l'UIPES. Depuis, elle a développé et élargi son rôle en tant qu'association professionnelle mondiale, indépendante, dédiée à la promotion de la santé et à l'équité en santé. L'UIPES est une ONG unique constituée de membres, qui reste fermement engagée à respecter ses principes fondateurs tout en focalisant ses objectifs stratégiques sur l'innovation et la transformation nécessaires pour faire progresser la promotion de la santé à l'échelle mondiale au cours des 70 prochaines années.

À l'occasion de ce 70ème anniversaire, ce numéro spécial rassemble un ensemble d'articles, de commentaires et de perspectives sur le passé, le présent et l'avenir de la promotion de la santé. Des points de vue critiques sont échangés sur le rôle de la promotion de la santé en tant que stratégie transformatrice essentielle pour faire progresser la santé humaine, le bien-être, l'équité et le développement durable face aux défis mondiaux à relever. Les articles et autres contributions étudient également de manière critique le rôle de l'UIPES dans le renforcement de la promotion de la santé à l'échelle mondiale, en travaillant avec ses membres et organismes partenaires pour faire progresser les politiques, les pratiques, les structures, les capacités et la recherche qui favoriseront la santé de la population, l'équité et le bien-être en santé et un avenir plus sain et durable pour tous.

La première série d'articles apporte des réflexions critiques sur l'état actuel et le développement de la promotion de la santé du point de vue des politiques, de la recherche et de la pratique. Dans mon propre article (Barry), j'examine comment on peut faire progresser la promotion de la santé en tant que stratégie transformatrice et je réfléchis de façon critique aux progrès qui doivent être réalisés de même qu'aux structures et aux processus nécessaires

Présidente de l'UIPES.

Correspondance à: Margaret M. Barry, Présidente de l'UIPES, School of Health Sciences, National University of Ireland Galway, University Road, Galway, Ireland. Email : margaret.barry@nuigalway.ie

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pour renforcer la promotion de la santé au niveau des systèmes. Les mécanismes nécessaires au niveau conceptuel, politique et de mise en œuvre propres à renforcer les systèmes de promotion de la santé sont discutés et le rôle essentiel de l'UIPES dans cette entreprise est décrit. L'article de De Leeuw et ses collègues aborde l'élaboration des politiques en promotion de la santé et introduit le concept d'une science politique de la santé pour la promotion de la santé. Des études de cas sont présentées pour illustrer la valeur ajoutée de la théorisation des sciences politiques de la santé appliquée à la promotion de la santé. Les auteurs appellent à une plus grande appréciation de la nature politique du domaine et à une meilleure compréhension des fondements conceptuels des processus politiques de la promotion de la santé. Potvin et Jourdan examinent l'état de développement de la recherche en promotion de la santé. Ils soutiennent que si la recherche en promotion de la santé est effectivement un domaine de recherche distinct, elle ne dispose pas actuellement d'un cadre unificateur pour structurer sa base de connaissances. Ils proposent trois piliers structurants qui s'appuient sur les pratiques de recherche existantes – l'objet, le but et la nature des connaissances générées par la recherche en promotion de la santé – et décrivent des travaux actuels qui offrent une orientation pour le processus de structuration. L'article de Van den Broucke traite du développement continu de la pratique en promotion de la santé en tant que domaine transdisciplinaire de la santé publique. Il décrit la contribution unique de la promotion de la santé à la santé publique et discute de l'importance de la formation des ressources humaines fondée sur des compétences clés essentielles à avoir ou à acquérir pour agir en promotion de la santé. Van den Broucke examine comment le développement des capacités en promotion de la santé peut être renforcé dans le contexte de l'intégration de la promotion de la santé dans la pratique de la santé publique. On retrouve l'accent mis sur le renforcement des capacités des ressources humaines dans un commentaire de Battel-Kirk et de ses collègues dans lequel ils rendent compte de l'élaboration et de la mise en œuvre du système d'accréditation de l'UIPES fondé sur un ensemble de compétences clés, pour former un système d'assurance qualité pour la pratique, l'enseignement et la formation en promotion de la santé dans le monde. Les auteurs fournissent un aperçu du fonctionnement du système d'accréditation et de son statut actuel. Des recherches sur son impact sur le développement des ressources humaines sont présentées et des perspectives d'avenir sont discutées.

La série d'articles suivante examine les orientations et les priorités futures de la promotion de la santé au 21ème siècle, en tenant compte des défis actuels et futurs. Un ensemble d'articles et de commentaires traitent de nouvelles approches et d'idées émergentes pour redéfinir le rôle de la promotion de la santé. Le commentaire de Nutbeam étudie la relation entre l'éducation pour la santé et la promotion de la santé et, en appliquant le prisme de la littératie en santé, la façon dont le passé peut façonner l'avenir. Nutbeam décrit les défis et les possibilités que présentent les nouvelles technologies numériques au service de la santé en permettant aux personnes d'accéder à l'information, d'interagir avec elle et de se fixer des objectifs en matière de santé. Le commentaire discute du rôle de l'éducation pour la santé centrée sur les compétences et de l'importance d'une littératie en santé interactive et critique qui utilise les médias numériques et qui favorise le développement de la capacité d'agir, le développement communautaire et l'activisme social en faveur de la santé.

Dans son commentaire sur la vision de l'avenir de la promotion de la santé, Kickbusch décrit des approches transformatrices pour promouvoir la santé et le bien-être. Elle soutient que la voie à suivre pour la promotion de la santé est de s'attacher à relever les défis de notre époque, notamment les inégalités, la crise climatique, les pandémies, la numérisation et l'affaiblissement de la démocratie. Elle examine de nouveaux modèles et approches et démontre comment, en embrassant la complexité, en développant de meilleures mesures transformatrices du bien-être et en aménageant des environnements favorables, on va permettre aux sociétés de bénéficier de politiques publiques intégrées favorables à la santé, au bien-être et au développement durable.

L'article de Baum examine à son tour comment la promotion de la santé peut être repensée pour faire face aux crises actuelles des inégalités croissantes, du réchauffement planétaire, de la pandémie et de la rupture de la confiance et de la solidarité dans les sociétés. L'article discute de la nécessité de prendre la santé planétaire plus au sérieux, et parle de l'importance d'utiliser la pensée systémique; de déterminer le rôle de la promotion de la santé dans la gouvernance de la santé et de l'équité en santé ; et

de comment concilier la promotion de la santé en tant que profession et en tant que mouvement social. Baum appelle à un agenda de la promotion de la santé plus radical qui puisse atteindre l'objectif d'une planète en santé, équitable et durable dans laquelle tous les humains peuvent s'épanouir.

Le thème de la santé planétaire est examiné de manière plus détaillée dans un article de Tu'ithai et de ses collègues qui aborde la question : « Comment améliorer la santé de la population – en particulier la santé des plus défavorisés et des plus vulnérables – tout en faisant la paix avec la Terre ? ». L'article donne un aperçu des changements écologiques à l'échelle mondiale entraînés par les forces sociales et économiques et examine leurs répercussions sur la santé. Les auteurs évoquent les Déclarations de la Conférence mondiale de 2019 de l'UIPES en promotion de la santé et appellent les promoteurs de la santé à faire preuve de leadership en promouvant un nouvel ensemble de valeurs compatibles avec la santé planétaire, s'appuyant sur les perspectives autochtones et spirituelles et abordant les déterminants écologiques et sociaux de la santé. Le commentaire qui suit, écrit par Magistretti et ses collègues, discute du rôle des mouvements populaires dans la santé planétaire et examine comment le discours sur le militantisme local peut être reformulé pour apparaître comme un processus salutogène global de changement. Le projet People-Planet-Health est présenté comme une nouvelle initiative d'échange de connaissances, qui vise à donner une voix et une visibilité aux groupes communautaires. Les auteurs appellent les acteurs de la promotion de la santé et les responsables de l'action publique mondiale à reconnaître et valoriser la contribution des mouvements populaires dans la création de la santé planétaire.

Ottemöller et ses collègues qui tous appartiennent au Réseau des étudiants et professionnels en début de carrière de l'UIPES abordent la question de l'équité en santé et explorent comment la théorie de la salutogenèse peut réinventer la promotion de la santé auprès des communautés marginalisées. L'article souligne la nécessité de reconnaître les causes profondes et historiques des inégalités en matière de santé, y compris l'influence des idéologies coloniales et occidentales. Un changement radical dans les approches actuelles est proposé avec un changement d'orientation de la pathologisation des communautés traditionnellement opprimées vers une approche de participation et d'engagement communautaires, en s'appuyant sur le savoir traditionnel et autochtone qui favorise la résilience et le bien-être des communautés marginalisées. Nous concluons cette section avec deux commentaires sur l'avancement des Objectifs de développement durable (ODD) dans les régions d'Afrique et d'Asie du Sud-Est. Munodawafa et ses collègues examinent la promotion de la santé sur le continent africain, en décrivant les stratégies et développements actuels à l'échelle régionale concernant la progression des ODD. Les défis spécifiques et les opportunités pour la promotion de la santé, y compris la lutte contre la pandémie actuelle de COVID-19, sont abordés et des recommandations sont formulées pour renforcer les politiques et les pratiques en promotion de la santé, en la plaçant au coeur de l'agenda de développement afin de réaliser les ODD dans la région. Mukhopadhyay et Kaur décrivent la situation en Asie du Sud-Est et soulignent l'importance d'investir dans la promotion de la santé pour atteindre les ODD. Ils discutent du développement de la promotion de la santé dans la région et de l'importance primordiale de s'attaquer aux déterminants sociaux de la santé, en particulier pour les populations vivant dans des conditions de misère économique et sociale.

Nous clôturons le numéro spécial par une série de perspectives de cinq des anciens Présidents de l'UIPES, qui partagent leurs réflexions personnelles et apportent un regard fascinant sur le développement de la promotion de la santé et de l'UIPES au cours des 20 dernières années et envisagent les développements futurs.

Je suis extrêmement reconnaissante à tous les auteurs et réviseurs qui ont contribué à ce numéro spécial et à la Rédactrice en chef, Erica Di Ruggiero, de même qu'à la Responsable des affaires scientifiques de l'UIPES, Ana Gherghel, dont le travail a permis que ce numéro puisse voir le jour. Je souhaite également souligner les contributions de tous les membres du personnel et membres de l'UIPES, passés et présents, et de tous ceux qui ont apporté leur soutien aux travaux de l'organisation depuis sa fondation. L'UIPES a été une voix cohérente de la promotion de la santé au fil des ans et un organe fédérateur essentiel du réseau mondial des personnes et des institutions qui se consacrent à faire progresser ce champ. Ce 70ème annniversaire

arrive à un moment critique de notre histoire, alors que nous nous frayons un chemin à travers la pandémie, en espérant mieux reconstruire dans un esprit plus juste, et ainsi planifier un avenir plus sain pour tous. La promotion de la santé doit être au premier plan de cette entreprise et placer la promotion de l'équité en santé au centre des programmes de santé, de bien-être et de développement durable. Le plein potentiel de la promotion de la santé n'a pas encore été réalisé et maintenant, plus que jamais, des actions transformatrices de promotion de la santé doivent être mises en place. Aujourd'hui, nous savons ce qui marche ; il est maintenant temps de mettre en œuvre des stratégies efficaces. L'UIPES continuera de soutenir cet effort mondial, en plaidant en faveur de l'équité en matière de santé et en soutenant la communauté mondiale des promoteurs de la santé afin de renforcer tous ensemble la promotion de la santé et sa mise en œuvre dans la pratique au cours des 70 prochaines années. J'espère que vous aurez plaisir à lire ce numéro special et que vous vous joindrez à nous pour célébrer ce 70ème anniversaire. Puisse l'UIPES rester toujours jeune !

Résumés

Promotion de la santé transformatrice : de quoi a-t-on besoin pour progresser ?

Margaret M. Barry

Des actions promotrices de santé transformatrices sont nécessaires pour atteindre l'équité en santé et les Objectifs de développement durable (ODD), faire progresser le bien-être humain et planétaire, et garantir la reconstruction de l'après-COVID-19 dans de meilleures conditions. Les politiques et les systèmes de santé doivent être alignés avec les valeurs, les principes et les stratégies de la promotion de la santé, de même qu'avec les investissements réalisés pour renforcer les fonctions essentielles de la promotion de la santé. Cet article examine la manière dont on peut faire progresser la promotion de la santé transformatrice en menant une réflexion critique sur les progrès qui doivent être réalisés, et sur les structures et les processus dont nous avons besoin pour renforcer la promotion de la santé à un niveau systémique. Les progrès réalisés dans la mise en œuvre de la promotion de la santé sont variables et il existe un manque général d'investissements dédiés au développement des systèmes de promotion de la santé qui sont nécessaires pour parvenir à des progrès conséquents. Les éléments clés et les exigences systémiques pour une promotion de la santé globale sont examinés, notamment les éléments fondamentaux suivants : (i) un plaidoyer efficace en faveur du concept et des pratiques de la promotion de la santé ; (ii) le fait de favoriser les structures politiques pour des actions promotrices de santé universelles sur une base intersectorielle ; (iii) des systèmes de mise en œuvre, des mécanismes de soutien et des capacités en main-d'œuvre efficaces pour une action promotrice de santé multisectorielle ; (iv) un investissement dans des méthodes de recherche novatrices et la traduction des connaissances afin de documenter les approches de promotion de la santé transformatrice. En renforçant les capacités pour mettre en œuvre des actions de promotion de la santé transformatrice, une volonté politique devra être mobilisée pour garantir la mise à disposition de financements dédiés et durables, et l'existence de capacités organisationnelles et professionnelles de manière à fournir des interventions promotrices de santé efficaces. L'Union internationale de Promotion de la Santé et d'Éducation pour la Santé (UIPES) joue un rôle central pour faire progresser la promotion de la santé transformatrice à travers la mobilisation et le soutien de ses membres et partenaires mondiaux afin de renforcer les systèmes de promotion de la santé. (Global Health Promotion, 2021; 28(4): 8–16)

Une science politique de la santé pour la promotion de la santé

Evelyne de Leeuw, Patrick Harris, Jinhee Kim et Aryati Yashadhana

Si la promotion de la santé, en tant que domaine de changement pour la santé humaine et écologique, doit maintenir son caractère urgent, elle doit continuer à développer la crédibilité de ses politiques. Cet article retrace le développement de politiques comme préoccupation pour l'UIES/l'UIPES (l'Union internationale d'Éducation pour la Santé/l'Union internationale de Promotion de la Santé et d'Éducation pour la Santé) à partir du milieu des années 1970, à l'époque où les « politiques d'éducation pour la santé » étaient des questions prédominantes, jusqu'au lancement des Politiques publiques favorables à la santé (dans les années 1980) et de la Santé dans toutes les politiques (dans les années 2000). Nous soutenons que des fondements conceptuels et théoriques solides existent pour encadrer la promotion de la santé et développer sa pertinence et sa connectivité de manière plus importante. Nous commençons par une courte introduction de la science politique (de la santé), puis nous illustrons l'urgence de ce débat à l'aide de trois études de cas. La première adopte une perspective réaliste critique sur le fait de « combler le fossé » chez les populations autochtones australiennes. À l'aide de données probantes récentes, elle démontre que le processus central d'élaboration de politiques a besoin d'un réalignement avec le récit autochtone. La seconde étude de cas examine la politique de la planification urbaine favorable à la santé et de l'équité en santé dans les villes. En adoptant un point de vue institutionnaliste de théorie critique, ce cas décrit à quel point les parallèles politiques et narratifs entre la théorie urbaine et l'équité en santé ont été sous-explorés. Avec une orientation explicite pour connecter les deux, le domaine pourrait devenir un moteur important et puissant pour améliorer la promotion de la santé et les politiques de santé publique. Le troisième cas décrit les langages, les cadres politiques et les différences dans quatre paradigmes urbains/de santé. Il montre que des biais politiques et pratiques inconscients existent

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dans les priorités et les processus politiques. Nous concluons par des observations et des recommandations sur le rôle de la promotion de la santé comme domaine conceptuel et champ d'activité. Nous montrons que tous les promoteurs de santé devraient être conscients de la nature politique de leurs initiatives. Des outils et des analyses existent pour aider l'action à l'avenir. (Global Health Promotion, 2021; 28(4): 17–25)

La recherche en promotion de la santé a atteint sa maturité ! Structurer le domaine d'après les pratiques des chercheurs en promotion de la santé

Louise Potvin et Didier Jourdan

La promotion de la santé est généralement présentée comme un discours et un ensemble de pratiques basés sur une série de valeurs et de principes qui promeuvent les changements à différents niveaux (individuel, communautaire et mondial). Elle n'a pas de base de connaissances bien définie ni de méthodes de développement des connaissances largement reconnues. Au cours des décennies écoulées, les connaissances en promotion de la santé se sont développées en suivant un modèle de « repas-partage ». Des chercheurs issus de différentes formations disciplinaires, séduits par les valeurs et la vision transformatrice de la promotion de la santé, ont utilisé les théories et les méthodes de recherche propres à leurs disciplines pour réaliser des études sur les diverses pratiques associées à la promotion de la santé. Cependant, même si la recherche en promotion de la santé a acquis de nombreuses qualités qui en font un domaine à part entière, la recherche de pratiques issues de différentes perspectives disciplinaires ne suffit pas à créer une base de connaissances cohérente pour la promotion de la santé. Nous proposons trois dimensions pour structurer davantage la recherche en promotion de la santé. La première se rapporte à l'objet pour lequel les connaissances sont produites. Pour la recherche en promotion de la santé, celui-ci est lié aux pratiques sociales de santé. La seconde dimension se rapporte aux objectifs et à l'éthique de la recherche. Dans le cas de la recherche en promotion de la santé, elle poursuit le double objectif de produire des connaissances (but épistémique) et de contribuer aux changements sociaux (but transformateur). La troisième dimension concerne les connaissances produites et les conditions pour qu'elles soient valables. Dans le cas de la recherche en promotion de la santé, les conditions de la production de connaissances devraient inclure une reconnaissance de la complexité des pratiques sociales et l'indispensable dialogue entre scientifiques. En ligne avec les principes de la promotion de la santé, nous proposons un processus ascendant pour structurer le domaine à travers la création d'un Global Handbook of Health Promotion Research, qui devrait s'appuyer sur les pratiques de recherche de ceux qui sont engagés dans la recherche en promotion de la santé. (Global Health Promotion, 2021; 28(4): 26–35)

Renforcer la pratique de la promotion de la santé : le développement des capacités pour un domaine transdisciplinaire

Stephan Van den Broucke

Le fardeau grandissant des maladies non transmissibles et des maladies transmissibles émergentes, de la multimorbidité, des inégalités de santé croissantes, des effets du changement climatique et des catastrophes naturelles sur la santé, et de la révolution des technologies de la communication nécessitent un changement de perspective vers des services de santé davantage axés sur la prévention, sur la communauté et sur les individus. Cela a des implications pour les professionnels de la santé, qui ont besoin de développer de nouvelles capacités et compétences, dont beaucoup se trouvent au cœur de la promotion de la santé. On assiste donc à l'intégration de la promotion de la santé dans la santé publique moderne. Pour la promotion de la santé, cela offre à la fois des opportunités et des défis à relever. Le fait de mettre davantage l'accent sur les éléments qui favorisent la santé améliore l'importance stratégique de l'approche de la santé propre à la promotion de la santé, qui tient compte de la société dans son ensemble ; valorise les réalisations de la promotion de la santé en matière de compétences professionnelles essentielles ; et permet de développer les

capacités de la santé publique dans une optique de promotion de la santé. D'un autre côté, généraliser la promotion de la santé est aussi susceptible d'affaiblir ses capacités organisationnelles et sa visibilité, et comporte un risque qu'elle soit absorbée dans un discours de santé publique traditionnel, dominé par les professions médicales. Pour aborder ces difficultés et saisir les opportunités qui se présentent, il est essentiel pour la main-d'œuvre de la promotion de la santé qu'elle se positionne elle-même au sein du domaine diversifié de la santé publique et des soins primaires. En prenant comme points de référence le statut transdisciplinaire de la promotion de la santé, et les systèmes de développement des capacités existants dans la prévention primaire et secondaire et en promotion de la santé, cet article considère les possibilités d'intégrer et de mettre en œuvre les capacités de la promotion de la santé à l'intérieur et au travers des frontières disciplinaires, en soutenant que la contribution de la promotion de la santé au développement de la santé publique réside dans la nature complémentaire de la promotion de la santé spécialisée et généralisée. (Global Health Promotion, 2021; 28(4): 36–45)

Le Système de certification en promotion de la santé de l'UIPES – développer et maintenir une main-d'œuvre compétente en promotion de la santé

Barbara Battel-Kirk, Shu-Ti Chiou, Liane Comeau, Ronan Dillon, Kirsten Doherty, Andrew Jones-Roberts, Tia Lockwood, Marguerite Claire Sendall, Viv Speller et Margaret M. Barry

Ce commentaire rapporte le développement et la mise en œuvre du Système de certification en promotion de la santé fondé sur les compétences de l'UIPES dans le contexte des capacités de la main-d'œuvre en tant qu'activité clé de l'Union internationale de Promotion de la Santé et d'Éducation pour la Santé (UIPES). Le processus de développement de ce système est décrit, notamment la manière dont il s'est appuyé sur les recherches et les expériences en matière d'approches basées sur les compétences à l'échelle internationale, et dont il les a complétées. Un aperçu du mode de fonctionnement de ce système, de son état actuel et de ses plans pour l'avenir est présenté. Des données concernant l'impact positif de ce système à ce jour, en particulier dans le contexte de l'éducation pour la santé, sont considérées. (Global Health Promotion, 2021; 28(4): 46–50)

De l'éducation pour la santé à la littératie numérique en santé – s'appuyer sur le passé pour construire l'avenir

Don Nutbeam

Au fil des décennies, l'éducation pour la santé n'a cessé d'évoluer et a revêtu plusieurs formes distinctes. L'émergence de nouveaux concepts tels que la promotion de la santé et la littératie en santé nous a permis de façonner et d'affiner notre compréhension de la manière dont l'objectif, le contenu et les méthodes de l'éducation pour la santé pouvaient s'adapter à de nouvelles méthodes et priorités de santé publique. Envisager l'éducation pour la santé à travers la perspective de la littératie en santé a été particulièrement utile pour distinguer l'éducation pour la santé traditionnelle, axée sur les tâches, de l'éducation pour la santé axée sur les compétences, conçue dans le but de développer des compétences plus générales et transférables. L'avènement des médias numériques a permis un accès sans précédents aux informations de santé, mais a également entraîné de nouvelles difficultés. La gestion du volume d'informations disponibles, et l'évaluation de leur qualité et de leur fiabilité sont devenues des compétences essentielles de la littératie numérique en santé à l'ère de l'information. En tant qu'éducateurs pour la santé, nous devons continuer à adapter nos pratiques à ces opportunités nouvelles et comprendre les difficultés qu'elles entraînent. (Global Health Promotion, 2021; 28(4): 51–55)

Une vision d'avenir pour la promotion de la santé

Ilona Kickbusch

La COVID-19 nous a clairement montré que le monde devait s'engager dans une approche transformatrice qui promeuve la santé et le bien-être. Le fait de vivre à l'ère de l'Anthropocène – une époque définie par l'impact humain sur nos écosystèmes – nous amène vers des territoires encore inconnus. Le défi est de trouver une manière de vivre qui vise à satisfaire les besoins de toutes les populations dans les limites des ressources de la planète vivante. Nous allons avoir besoin de clairvoyance, de flexibilité et de résilience pour bien nous préparer. Les risques auxquels nous sommes confrontés à l'échelle planétaire sont énormes et ils sont interconnectés – même si l'opportunité d'accélérer le changement vers un mieux est tout aussi extraordinaire. Nous disposons de modèles, de connaissances et de technologies susceptibles d'améliorer significativement la santé et le bien-être, et de créer des sociétés plus justes et plus durables – même s'ils n'ont pas été largement utilisés pour servir les intérêts du public et aborder les inégalités. (Global Health Promotion, 2021; 28(4): 56–63)

En quoi la promotion de la santé peut-elle contribuer à éviter le pire à l'humanité ?

Fran Baum

La promotion de la santé a évolué au cours des dernières décennies pour passer d'une vision principalement axée sur le changement comportemental à un ambitieux objectif qu'est celui de créer des environnements sains, justes et durables, qui concrétisent les droits de tous à la santé et au bien-être, tout en protégeant la santé de notre planète et ses écosystèmes. Cet article soutient que pour contribuer à cet ambitieux objectif, la promotion de la santé doit aborder trois tâches essentielles. La première est la nécessité de prendre la santé planétaire plus au sérieux, et de se détacher d'une pensée réductionniste pour aller vers une approche considérant la planète comme un système complexe, valorisant davantage l'harmonie avec la nature, préservant la biodiversité, et luttant contre le réchauffement climatique. La seconde de ces tâches est le plaidoyer et le soutien aux gouvernements pour qu'ils travaillent d'une manière favorable à la santé. La clé pour y arriver serait de faire passer la santé et l'équité avant le profit, de créer des environnements urbains favorables à la santé, d'encourager la prise de décisions participative, de plaider pour des modèles économiques favorables à la santé, et d'évaluer la manière dont fonctionnent les déterminants de la santé au sein de l'entreprise. La troisième tâche est de garantir que les changements destinés à professionnaliser la promotion de la santé ne se fassent pas aux dépens du plaidoyer de la promotion de la santé pour renforcer les individus et les organisations. La promotion de la santé est bien placée pour soutenir les mouvements de la société civile en plaidant pour un changement économique et social qui bénéficiera à la santé, comme le mouvement *Black Lives Matter* et les mouvements pour l'environnement. (Global Health Promotion, 2021; 28(4): 64–72)

Waiora : l'importance de la spiritualité et des visions du monde autochtones pour inspirer et documenter la promotion de la santé planétaire à l'ère de l'Anthropocène

Sione Tu'itahi, Huti Watson, Richard Egan, Margot Parkes et Trevor Hancock

Nous vivons à présent dans une nouvelle ère géologique, l'Anthropocène – l'ère des humains – dont le point de départ coïncide avec la création de l'UIPES, il y a 70 ans. Dans cet article, nous abordons le défi fondamental auquel sera confrontée la promotion de la santé dans les 70 prochaines années, ce qui nous amène jusqu'en 2100 : comment parvenir à la santé planétaire ? Nous commençons par un bref aperçu des changements

écologiques massifs et rapides auxquels nous sommes confrontés à l'échelle planétaire, des forces motrices sociales, économiques et technologiques qui sous-tendent ces changements, et de leurs implications pour la santé. Cependant, au cœur de ces forces motrices, on trouve une série de valeurs essentielles qui sont incompatibles avec la santé planétaire. La nécessité d'une nouvelle série de valeurs est donc au centre de notre propos ; celle-ci considérerait et privilégierait la sagesse des visions du monde autochtones, de même qu'un sens renouvelé de la spiritualité susceptible de rétablir le respect profond de la nature. Nous proposons un cadre élaboré d'après les visions autochtones pour inspirer et documenter ce que nous appelons la promotion de la santé planétaire, de manière à ce que nous puissions, comme le Secrétaire général de l'ONU l'a écrit récemment, faire la paix avec la nature. (Global Health Promotion, 2021; 28(4): 73–82)

People-Planet-Health : promouvoir les mouvements populaires à travers la coproduction participative

Claudia Meier Magistretti, Jake Sallaway-Costello, Shadhaab Fatima et Rachel Hartnoll

La menace du changement climatique anthropique nécessite une action immédiate pour éviter de causer des dommages supplémentaires à la santé humaine et aux écosystèmes naturels fragiles. Ce processus de changement pourrait déjà avoir commencé à l'échelle locale, sous la direction d'organisations populaires à travers le monde. En concevant leurs actions comme une forme de salutogénèse, ces organisations développent un sens de la cohérence afin d'encourager les communautés à participer au défi potentiellement écrasant de la santé planétaire. People-Planet-Health vise à faire entendre et connaître ces groupes et leurs actions. Des contributeurs seront par la suite invités à participer à l'élaboration d'un document de position destiné à documenter la Stratégie mondiale révisée de l'OMS pour la promotion de la santé. (Global Health Promotion, 2021; 28(4): 83–87)

Donner une nouvelle vision à la promotion de la santé : penser et agir de manière salutogène en vue de l'équité pour les communautés historiquement résilientes

Fungisai Gwanzura Ottemöller, Tulani Francis L. Matenga, Hope J. Corbin, Humaira Nakhuda, Peter Delobelle, Christa Ayele, Nikita Boston-Fisher, Stephanie Leitch, Josette Wicker et Oliver Mweemba

Cet article examine la manière dont la théorie salutogène peut nous permettre de réenvisager le travail de la promotion de la santé auprès des communautés marginalisées, en vue d'une approche qui reconnaisse et valorise leur résilience. Nous utilisons les trois concepts centraux du modèle salutogène de la santé d'Antonovsky – sens de la cohérence, ressources de résistance générales et ressources de résistance spécifiques – afin d'examiner la pertinence de cette théorie par rapport à l'équité en santé, en présentant ainsi de nouvelles opportunités pour la manière dont nous devrions réévaluer radicalement les approches actuelles de promotion de la santé. Nous concluons qu'une promotion de la santé plus équitable nécessite une participation accrue des communautés marginalisées à la détermination de leurs futurs, et suggérons un nouveau modèle pour une promotion de la santé salutogène fondée sur des bases historiques. (Global Health Promotion, 2021; 28(4): 88–96)

Atteindre les ODD et aborder les urgences de santé en Afrique : renforcer la promotion de la santé

Davison Munodawafa, Handsome Onya, Mary Amuyunzu-Nyamongo, Oliver Mweemba, Peter Phori et Aminata Kobie

En 1986, l'Organisation mondiale de la Santé (OMS) a organisé la première Conférence mondiale sur la promotion de la santé qui s'est tenue à Ottawa, au Canada. Cette conférence a donné lieu à la Charte d'Ottawa qui a défini la promotion de la santé comme le processus permettant aux individus d'accroître leur contrôle sur leur santé et de l'améliorer. Elle a été suivie par une série de conférences et en 2005, l'OMS a organisé la 6e Conférence mondiale à Bangkok, en Thaïlande, qui a donné lieu à la Charte de Bangkok pour la promotion de la santé. Cette charte étendait pour la première fois le rôle de la promotion de la santé pour inclure le fait d'aborder les déterminants sociaux de la santé. En 2012, les ministres de la Santé des 47 pays du Bureau régional de l'OMS pour l'Afrique ont approuvé le document « Promotion de la santé : stratégie pour la région africaine ». Cette stratégie a mis en avant huit interventions prioritaires qui sont nécessaires si l'on veut aborder les facteurs de risque pour la santé et leurs déterminants. En 2011, la Déclaration politique de Rio sur les déterminants sociaux de la santé a été adoptée par les ministres de la Santé et des groupes de la société civile pour aborder les inégalités et les injustices au sein des populations et entre elles. Ses principaux domaines d'action étaient la bonne gouvernance pour lutter contre les causes fondamentales des inégalités de santé ; la promotion de la participation et du sentiment d'appropriation ; le leadership communautaire pour l'action sur les déterminants sociaux ; l'action globale sur les déterminants sociaux pour aligner les priorités et les parties prenantes ; et la surveillance des progrès réalisés sur la mise en œuvre des politiques et des pratiques. La promotion de la santé a joué un rôle majeur dans le cadre de la réponse apportée à certaines épidémies, notamment celle d'Ebola et celle de la COVID-19. Elle a fait partie intégrante de l'amélioration de la mortalité et de la morbidité dans le cadre de la santé maternelle et infantile, de même que de la tuberculose, du VIH/SIDA et de la malaria ; et dernièrement, pour réduire l'impact des maladies non transmissibles que sont le diabète, l'hypertension artérielle et le cancer. Tandis que les défis se poursuivent pour renforcer la promotion de la santé, des efforts concertés ont été réalisés pour inscrire la promotion de la santé à l'ordre du jour des pays en matière de développement au travers de la « Santé dans toutes les politiques » (HiAP), du renforcement des capacités, de la surveillance et de l'évaluation, et d'options de politiques financières innovantes à l'aide de taxes à affectation spécifique sur le tabac et l'alcool, et la circulation routière. (Global Health Promotion, 2021; 28(4): 97–103)

Redéfinir la promotion de la santé pour atteindre les laissés-pour-compte : des opportunités pour un changement transformateur en Asie du Sud et du Sud-Est

Alok Mukhopadhyay et Nancepreet Kaur

La pandémie a révélé la vulnérabilité de notre civilisation et renforcé l'importance de vivre en harmonie avec la nature, plutôt que de la saccager de manière collective. L'Asie du Sud et du Sud-Est a un rôle essentiel à jouer pour atteindre l'objectif mondial de la « Santé pour tous », étant donné que ces régions présentent une part très importante des revenus mondiaux et de pauvreté multidimensionnelle, comparativement aux autres régions. Il est évident que des progrès dans les résultats de santé et de développement de ces régions ne peuvent être réalisés sans aborder les déterminants sociaux de la santé et sans garantir la participation active du public. Ces régions doivent aborder collectivement les déterminants sociaux de la santé en suivant un modèle réaliste de promotion de la santé. Le moment est effectivement favorable pour regarder au-delà du modèle biomédical des soins de santé que l'on qualifie de principalement réductionniste vers un modèle plus holistique de la santé qui place l'humain et l'environnement au centre, et mette l'accent sur l'importance de promouvoir la santé et le bien-être. (Global Health Promotion, 2021; 28(4): 104–108)

"Una mirada al futuro de la Promoción de la Salud: aprender del pasado, preparar el futuro"

Liane Comeau[1] y Marie-Claude Lamarre[2]

"Una conmemoración no constituye un punto de llegada: solo es una pausa que nos invita a una reflexión constructiva y que envuelve en una misma dinámica un balance dirigido hacia el futuro y una perspectiva enraizada en el pasado". (1)

Cuando celebramos un aniversario conmemoramos una fecha especial, la de un nacimiento, una fundación, una boda o un fallecimiento. Se trata de un punto de anclaje y de referencia en el tiempo que está relacionado con una persona, una institución o un evento, con la continuidad de una historia y que, además, nos reúne. En este caso, nos referimos a la celebración del nacimiento de una institución que cuenta para una comunidad y en nuestro mundo.

Celebramos los 70 años de la creación de la Unión Internacional de Promoción de la Salud y Educación para la Salud (UIPES), en París, en mayo de 1951. Se trata de un momento excepcional para reafirmar nuestro compromiso por un mundo más equitativo y para mirar con optimismo hacia el futuro de la promoción de la salud. Celebramos valores y principios – en especial la justicia social y la equidad, la diversidad, el poder de actuar sobre nuestra propia salud y sobre la de nuestra comunidad, y el trabajo en asociación – que nos congregan en la promoción de la salud y que hacen que nos reconozcamos en un espacio de salud pública cada vez más enmarañado de conceptos, teorías más o menos conceptuales, y de prácticas.

Celebramos la contribución única de la promoción de la salud como una respuesta a los desafíos de nuestras sociedades, en el nivel en el que estemos – local, regional, nacional o internacional – en complementaridad y con respeto para las funciones y misiones respectivas en los medios políticos, académicos y prácticos. El trabajo entre los sectores en favor de la salud y del bienestar, además, parece cada vez más pertinente en un mundo complejo en el que la salud es tributaria de múltiples factores.

Esta edición especial de *Global Health Promotion* y la calidad de su contenido, constituyen un excelente regalo de aniversario para la UIPES, para sus miembros y para los lectores de la Revista. Combinar los puntos de vista de varias generaciones de pensadores, investigadores y profesionales da la sensación de un "encuentro de familia", la de los miembros y socios cercanos a la historia y la evolución de la UIPES, que reúne a los líderes y visionarios de la promoción de la salud que tanto la han servido, y a los representantes de las nuevas generaciones. Este número especial propone una reflexión sobre cómo continuar avanzando en la promoción de la salud, alrededor del mundo, en aspectos como la investigación, la práctica y el desarrollo de las políticas públicas.

Como lo sabemos todos, no existe una concepción única y universal de la promoción de la salud, sino una concepción plural que se inscribe en una historia de la salud pública, en condiciones políticas, culturales, sociales y económicas locales y en sistemas. Lo que enlaza estas visiones es que de común acuerdo se aborda la salud como una empresa social a través de un conjunto de estrategias desarrolladas conjuntamente para alcanzar un mismo objetivo en el que estén incluidas la defensa, la educación, la capacitación, la investigación, la concepción de leyes, la coordinación de políticas y el desarrollo comunitario, cualesquiera que sean los problemas que haya que resolver, las poblaciones afectadas o los contextos y los medios de vida.

Otro nexo común es el de enfocarse en los múltiples determinantes de la salud y asociar los logros en materia de salud con ajustes estructurales que aportan cambios políticos, económicos, ambientales y sociales. En este sentido, el discurso actual sobre los cambios

1. Directora Ejecutiva de la UIPES, Montréal, Québec, Canada.
2. ex Directora Ejecutiva de la UIPES, Paris, Saint-Maurice, France.

Correspondencia a: Liane Comeau, Directora Ejecutiva de la UIPES, c/o École de Santé Publique, Université de Montréal, 7101 avenue du Parc, Montréal, QC H3N 1X9, Canada. Email: lcomeau@iuhpe.org

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climáticos y sus repercusiones en las poblaciones, así como los Objetivos de Desarrollo Sostenible de la ONU, proporcionan anclajes para actuar sobre el conjunto de determinantes de la salud de manera coordinada y sistémica. La pandemia de la COVID-19 que vivimos actualmente pone de relieve, igualmente, las fallas de nuestras sociedades y resalta la importancia de los enfoques sistémicos para reducir las brechas y favorecer la salud y el bienestar de todos.

Celebramos entonces 70 años de participación y de aprendizaje, de reflexión compartida sobre el papel y el sentido de la salud y de la promoción de la salud en nuestras sociedades contemporáneas, de innovación, de ensayos y errores y de logros. No hay ninguna duda, sin embargo, en cuanto a la pertinencia de este campo, de sus enfoques y de sus métodos para enfrentar los desafíos del presente y del futuro.

Celebramos 70 años de colaboraciones, de relaciones que nos sobreviven mediante la transmisión y la difusión de ideas, de conocimientos y de experiencias, y nuestra complementariedad es una prueba de eficacia en la búsqueda de nuestros objetivos comunes. Hacer parte de la Unión Internacional de Promoción de la Salud y Educación para la Salud es hacer parte de una comunidad comprometida. Participar en sus proyectos, sus eventos, su proyección, es tener el privilegio de trabajar al lado de los mejores, de intercambiar ideas y de aprender de ellos. La existencia y la riqueza de la UIPES es la de sus miembros, de su diversidad de conocimientos y de prácticas acumuladas a lo largo de los años. Esta comunidad mundial de individuos y de instituciones es abierta, inclusiva y acoge continuamente a nuevos miembros.

La presente edición especial de *Global Health Promotion* mide el camino recorrido y destaca las principales cuestiones de la promoción de la salud que siguen suscitando numerosos debates: la valorización y el reconocimiento de nuestro ámbito y nuestro campo de acción, su inclusión en una cultura, la complejidad de la organización de la promoción de la salud en el marco político y en una perspectiva sistémica, así como la necesidad de capacitación en todos los niveles, con el fin de conciliar el discurso y las acciones y de desarrollar nuevas generaciones de actores calificados, competentes y motivados.

¡Esperamos que esta publicación contribuya a abrir la vía a nuevas perspectivas y proyectos de sociedad basados en la evidencia acumulada en todo el mundo a lo largo de los años!

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Una mirada al futuro de la Promoción de la Salud: aprender del pasado, preparar el futuro

Margaret M. Barry

Es un honor ser la editora invitada de esta edición especial que señala los 70 años de la fundación de la Unión Internacional de Promoción de la Salud y Educación para la Salud (UIPES). Este número de aniversario nos ofrece una oportunidad para hacer una reflexión crítica sobre la evolución y el desarrollo futuro de la promoción de la salud y considerar el papel de la UIPES en el fomento de este campo ahora y en los años venideros.

La 'Unión Internacional de Educación para la Salud' fue creada oficialmente en 1951. Esta agencia no gubernamental fue fundada por el Profesor Jacques Parisot, profesor de Salud Pública de la Escuela de Medicina de Nancy (Francia), y por Lucien Viborel, director del Centro Nacional para la Educación para la Salud del Ministerio de Salud Pública de Francia. El gobierno francés promovió la organización de la Asamblea Constituyente de la Unión en mayo de 1951 en una conferencia internacional en París. Eran épocas de grandes cambios, consecuencia de la Segunda Guerra Mundial, que resaltaban la urgente necesidad de la cooperación mundial. La Organización de las Naciones Unidas fue fundada en 1945 y se creó la Organización Mundial de la Salud como una agencia especializada responsable de la salud pública internacional con el objetivo de promover y proteger la salud de todos los pueblos. El establecimiento de la Unión Internacional solo unos pocos años después resultó visionario y estratégico, al constatar que se necesitaba una movilización mundial de personas y organizaciones comprometidas con la promoción de la salud de la población para acompañar la visión y el trabajo de agencias como la Organización Mundial de la Salud. Durante estos 70 años, la Unión Internacional ha crecido y desarrollado su misión principal y, en 1993, completó su nombre para abarcar también la Promoción de la Salud y convertirse en la UIPES. Desde entonces, ha perfeccionado y expandido su papel como una asociación profesional mundial independiente, dedicada a fomentar la promoción de la salud y la equidad en salud.

Como única ONG basada en el sistema de membresía, la UIPES continúa comprometida firmemente con sus principios fundadores, al tiempo que mantiene su enfoque estratégico en la innovación y la transformación necesaria para fomentar la promoción de la salud mundial por otros 70 años.

Para celebrar el aniversario de la UIPES, este número especial reúne una colección de artículos, comentarios y perspectivas sobre el pasado, el presente y el futuro de la promoción de la salud. Es un espacio para el intercambio de puntos de vista críticos sobre el papel de la promoción de la salud como una estrategia clave transformadora para promover la salud humana, el bienestar, la equidad y el desarrollo sostenible de cara a los desafíos mundiales. Los artículos también analizan la función de la UIPES en el fortalecimiento de la promoción de la salud en el mundo, su trabajo con miembros y agencias aliadas para impulsar políticas, prácticas, estructuras, capacidades e investigación que podrán promover la salud de la población, la equidad en salud y el bienestar, así como un futuro más saludable y sostenible para todos.

El primer conjunto de documentos ofrece unas reflexiones críticas sobre el estado actual y el desarrollo de la promoción de la salud desde la perspectiva de las políticas, la investigación y la práctica. En mi artículo (Barry) analizo cómo se puede fomentar una promoción de la salud transformadora y presento una reflexión crítica sobre los progresos que deben realizarse y las estructuras y procesos que se requieren para fortalecer la promoción de la salud en los sistemas. Se discuten igualmente los mecanismos facilitadores necesarios para reforzar los sistemas de promoción

Presidenta de la UIPES.

Correspondencia a: Margaret M. Barry, Presidenta de la UIPES, School of Health Sciences, National University of Ireland Galway, University Road, Galway, Ireland. Email : margaret.barry@nuigalway.ie

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de la salud a niveles conceptual, político y de implementación, y se plantea el papel crítico de la UIPES en este empeño.

El artículo de De Leeuw y sus colegas traza el desarrollo de las políticas en la promoción de la salud e introduce el concepto de ciencia política de la salud para la promoción de la salud. Presenta estudios de caso con los cuales ilustra el valor de aplicar la teoría de ciencia política de la salud a la promoción de la salud. Los autores piden una mayor apreciación de la naturaleza política del campo y una profundización en la fundamentación conceptual de los procesos políticos de la promoción de la salud.

Potvin y Jourdan examinan el estado del desarrollo de la investigación en la promoción de la salud. Sostienen que si bien la investigación en promoción de la salud es un campo distinto de investigación, actualmente carece de un marco unificador para articular su base de conocimientos. Proponen tres pilares estructurales que construyen sobre la práctica existente de la investigación en promoción de la salud: el objeto, el propósito y la naturaleza del conocimiento generado desde la investigación en promoción de la salud y subrayan el trabajo actual que ofrece una dirección al proceso de estructuración.

Van den Broucke aborda en su artículo el desarrollo continuo de la práctica de la promoción de la salud como un campo transdisciplinario en la salud pública. Presenta la contribución única de la promoción de la salud a la salud pública y analiza la importancia que tiene para la práctica de la promoción de la salud el hecho de desarrollar la fuerza laboral en función de las competencias básicas. Considera cómo se podría fortalecer el desarrollo de la capacidad de la promoción de la salud en el contexto de su integración a la práctica de la salud pública.

El enfoque en el desarrollo de la capacidad de la fuerza laboral aparece también en el comentario de Battel-Kirk y sus colegas, quienes presentan el desarrollo y la implementación del Sistema de Acreditación de la UIPES basado en las competencias como un sistema que garantiza la calidad de la práctica, la educación y la capacitación de la promoción de la salud a nivel mundial. Ofrecen una descripción general del funcionamiento del Sistema de Acreditación y su estado actual, exponen la investigación sobre su impacto en el desarrollo de la fuerza laboral y discuten los planes para su futuro.

Otro conjunto de artículos analiza las futuras orientaciones y prioridades de la promoción de la salud en el siglo XXI, teniendo en cuenta los desafíos actuales y los venideros. Una serie de artículos y comentarios estudia nuevos enfoques e ideas emergentes para reconsiderar el papel de la promoción de la salud. El comentario de Nutbeam observa la relación entre la educación para la salud y la promoción de la salud y, aplicando la lente del alfabetismo para la salud, plantea cómo la construcción del pasado puede moldear el futuro. Nutbeam describe los desafíos y las oportunidades que presentan las nuevas tecnologías en salud digital para permitir que las personas tengan acceso a la información en salud, interactúen con ella y establezcan sus propias metas de salud. El artículo analiza el papel de la educación para la salud basada en las competencias y la importancia de un alfabetismo para la salud interactivo y crítico comprometido con los medios digitales, el apoyo al empoderamiento, al desarrollo comunitario y al activismo social para la salud.

Kickbusch, en su comentario sobre la visión del futuro de la promoción de la salud, describe los enfoques transformadores para la promoción de la salud y el bienestar. Ella sostiene que la promoción de la salud debe seguir un camino trazado para enfrentar los desafíos de nuestro tiempo, como las inequidades, la crisis climática, las pandemias, la digitalización y el debilitamiento de la democracia. Considera nuevos modelos y enfoques y examina cómo la adopción de la complejidad, la medición transformadora del bienestar y el diseño de entornos propicios permitirán a las sociedades beneficiarse de políticas integradas que promuevan la salud, el bienestar y la sostenibilidad.

El artículo de Baum plantea cómo se podría reformular la promoción de la salud para abordar las crisis ocasionadas actualmente por las crecientes inequidades, el calentamiento global, la pandemia y la fractura de la confianza y la solidaridad en las sociedades. Reflexiona sobre la necesidad de tomar más en serio la salud planetaria, la importancia de utilizar un pensamiento sistémico, de determinar la función de la promoción de la salud en la gobernanza por la salud y la equidad en salud, y cómo equilibrar la promoción de la salud entre la profesión y el movimiento social. Baum pide un programa más radical de promoción de la salud que pueda lograr el objetivo de un planeta más saludable, equitativo y

sostenible en el cual todos los seres humanos puedan prosperar.

El tema de la salud planetaria se detalla más ampliamente en el artículo de Tu'itahi y sus colegas, quienes se preguntan "¿cómo mejorar la salud de la población, especialmente la salud de los más vulnerables y desamparados, al tiempo que hacemos las paces con la Tierra?" Este texto ofrece un panorama de los cambios ecológicos mundiales que han sido ocasionados por fuerzas sociales y económicas y considera sus implicaciones en la salud. Los autores retoman las Declaraciones que quedaron como legado de la Conferencia Mundial de Promoción de la Salud de la UIPES 2019 y hacen un llamado a los promotores de la salud para que asuman el liderazgo en la promoción de un nuevo conjunto de valores compatibles con la salud planetaria, el aprovechamiento de las perspectivas indígenas y espirituales y el tratamiento de los determinantes sociales y ecológicos de la salud.

El comentario de Magistretti y sus colegas analiza el papel de los movimientos populares en la salud planetaria y considera cómo reformular el discurso sobre el activismo popular como un proceso de cambio mundial salutogénico. El proyecto People-Planet-Health se presenta como una nueva iniciativa de intercambio de conocimiento que busca darles voz y visibilidad a los grupos populares. Los autores les piden a los profesionales de la promoción de la salud y a los legisladores mundiales que reconozcan y valoren la contribución de los movimientos populares en la creación de la salud planetaria.

Ottemöller y sus colegas, de la Red de Estudiantes y Profesionales noveles de la UIPES (ISECN), abordan la equidad en salud y exploran cómo la teoría de la salutogénesis puede replantear la promoción de la salud con comunidades marginadas. El artículo esboza la necesidad de comprender las causas históricas y profundamente arraigadas de las inequidades en salud, incluyendo las influencias de las ideologías coloniales y occidentales. Propone una transformación radical en los actuales enfoques al dejar atrás la idea de patologizar las comunidades tradicionalmente oprimidas y en cambio fomentar el compromiso y la participación comunitarios, basados en el conocimiento indígena y tradicional, para así promover la resiliencia y el bienestar de las comunidades marginadas.

Concluimos esta sección con dos comentarios sobre el progreso de los Objetivos de Desarrollo Sostenible (ODS) en las regiones de África y del Sureste asiático.

Munodawafa y sus colegas reflexionan sobre la promoción de la salud en el continente africano, resaltando las estrategias regionales actuales y los progresos en el respeto de los ODS. Discuten los desafíos específicos y las oportunidades de la promoción de la salud, así como la forma de abordar la actual pandemia de la COVID-19, y ofrecen recomendaciones para fortalecer las políticas y la práctica de la promoción de la salud, ubicándola en el centro de la agenda de desarrollo con el fin de lograr los ODS en la región.

Mukhopadhyay y Kaur destacan la situación en el Sureste asiático y plantean la importancia de invertir en la promoción de la salud para lograr los ODS. Analizan el desarrollo de la promoción de la salud en la región y la importancia primordial de abordar los determinantes sociales de la salud, especialmente para las poblaciones que viven en condiciones de privación económica y social.

Cerramos este número especial con una serie de perspectivas de los cinco expresidentes de la UIPES, quienes comparten sus reflexiones personales, interesantes ideas sobre el progreso de la promoción de la salud y la UIPES durante los últimos 20 años, y consideran los futuros desarrollos.

Estoy sumamente agradecida con todos los autores y los revisores que contribuyeron en este número especial, con la Jefa de Redacción, Profesora Erica Di Ruggiero, y con la Responsable de Asuntos Científicos de la UIPES, Dra. Ana Gherghel, por hacer posible esta edición. También quiero reconocer la contribución del personal y los miembros de la UIPES, antiguos y actuales, y todos los que han apoyado el trabajo de la organización desde su fundación. La UIPES ha sido una voz constante para la promoción de la salud a través de los años y se ha constituido como una plataforma vital para unificar la red mundial de personas y organismos dedicados a este campo.

Celebramos estos 70 años en un momento crítico, mientras avanzamos en medio de la pandemia, con el objetivo de construir mejor y de forma más justa y planificar así un futuro más saludable para todos. La promoción de la salud tiene que estar al frente de este esfuerzo, haciendo que la promoción de la equidad en salud se posicione en el centro de los programas de salud, bienestar y desarrollo sostenible. Todavía no se ha explotado todo el potencial de la promoción de la salud y ahora, más que nunca, es

necesario adoptar medidas de promoción de la salud transformadoras. Sabemos qué funciona y este es el momento de poner en práctica estrategias eficaces. La UIPES seguirá apoyando este esfuerzo mundial, abogando por la equidad en salud y respaldando a la comunidad mundial de promotores de salud para unirse en el fortalecimiento de la promoción de la salud y su implementación en la práctica durante los próximos 70 años. Espero que disfruten leyendo este número especial y que se unan a nosotros en la celebración de este aniversario.

¡Que la UIPES continúe joven por siempre!

Resúmenes

Promoción de la salud transformativa: ¿Qué se necesita para avanzar?

Margaret M. Barry

Las acciones de promoción de la salud transformativa son necesarias para alcanzar la equidad en salud y los Objetivos de Desarrollo Sostenible (ODS), promover el bienestar humano y planetario, y asegurar una mejor reconstrucción pos-COVID-19. Las políticas y los sistemas de salud deben estar alineados con los valores, los principios y las estrategias de la promoción de la salud y la inversión en el fortalecimiento de las funciones esenciales de la promoción de la salud. En este artículo se analiza cómo se puede fomentar la promoción de la salud transformativa a través de una reflexión crítica sobre los pasos que se deben efectuar y las estructuras y los procesos requeridos para fortalecer la promoción de la salud a nivel de los sistemas. El progreso en la implementación de los sistemas de promoción es variable y hay una falta generalizada de inversión en el desarrollo de los sistemas de promoción de la salud necesarios para lograr un avance considerable. Se evalúan los requerimientos del sistema y los facilitadores claves de una promoción integral de la salud, entre los que se cuentan los siguientes elementos críticos: i) defensa efectiva del concepto y la práctica de la promoción de la salud; ii) estructuras políticas favorables para las acciones universales de promoción de la salud con una base intersectorial; iii) métodos de implementación efectivos, mecanismos de soporte y capacidad de fuerza laboral para poner en práctica la promoción multisectorial de la salud; iv) inversión en métodos de investigación innovadores y en traducción de conocimientos para informar los enfoques de la promoción de la salud transformativa. En el fortalecimiento de la capacidad para poner en práctica las acciones de promoción de la salud transformativa será necesario movilizar la voluntad política que asegure la disponibilidad de financiación específica y sostenible, y la capacidad organizacional y laboral que permita llevar a cabo intervenciones efectivas de promoción de la salud. La Unión Internacional de Promoción de la Salud y Educación para la Salud (UIPES) desempeña un papel fundamental en el fomento de la promoción de la salud transformativa a través de la movilización y el apoyo a sus miembros y socios mundiales en el fortalecimiento de los sistemas de promoción de la salud. (Global Health Promotion, 2021; 28(4): 8–16)

Una ciencia política de la salud para la promoción de la salud

Evelyne de Leeuw, Patrick Harris, Jinhee Kim y Aryati Yashadhana

Para que la promoción de la salud, como un área de cambio para la salud humana y ecológica, mantenga su carácter trascendental, es necesario que siga construyendo sus credenciales normativas. Este artículo describe el desarrollo de las políticas como una preocupación para la UIES/UIPES (Unión Internacional de Educación para la Salud / Unión Internacional de Promoción de la Salud y Educación para la Salud) desde mediados de los años 70 cuando 'las políticas de educación para la salud' eran un asunto relevante, hasta el lanzamiento de las Políticas Públicas Saludables (en los años 80) y de Salud en Todas las Políticas (en los años 2000). Consideramos que existen sólidos fundamentos conceptuales y teóricos para enmarcar y desarrollar la relevancia y la conectividad de la promoción de la salud de manera más prominente. Comenzamos con una breve introducción a la ciencia política (de la salud) y posteriormente ilustramos su urgencia con tres estudios de caso. El primero contempla una perspectiva crítica realista sobre 'el cierre de la brecha' en las poblaciones indígenas australianas. Con la evidencia reciente se demuestra que el foco del proceso de formulación de políticas necesita realinearse con una narrativa indígena. El segundo estudio de caso revisa las políticas de planificación urbana saludable y de equidad en salud en las ciudades. Adoptando una visión institucionalista de la teoría crítica, el caso describe cómo los paralelos políticos y narrativos entre la teoría urbana y la equidad en salud han sido poco explorados. Con una mirada explícita para conectarlas, el sector podría convertirse en motor importante e influyente de una mayor promoción de la salud y de las políticas de salud pública. El tercer caso describe los lenguajes, los marcos normativos y las distinciones en cuatro paradigmas urbanos/de salud. Refleja la existencia de una política inconsciente y una práctica sesgada dentro de los procesos y las prioridades políticas. Concluimos con una serie de observaciones y recomendaciones sobre el papel de la promoción de la salud como ámbito conceptual y campo de actividad. Demostramos que todos

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los promotores de la salud deben ser conscientes de la naturaleza política de su empresa. Existen instrumentos y análisis para ayudar a adoptar nuevas acciones. (Global Health Promotion, 2021; 28(4): 17–25)

¡La investigación en promoción de la salud llegó a la mayoría de edad! Estructurar el campo con base en las prácticas de los investigadores

Louise Potvin y Didier Jourdan

La promoción de la salud se enmarca principalmente como un discurso y unas prácticas basados en un conjunto de valores y principios que promueven cambios en varios niveles (individual, comunitario y mundial). No hay una base de conocimientos bien definida y no existen métodos de desarrollo del conocimiento que hayan sido ampliamente acordados. Durante las décadas pasadas, el conocimiento de la promoción de la salud se desarrolló siguiendo un modelo de "cada quien aporta algo". Los investigadores de diferentes disciplinas, interesados en los valores y la visión transformativa de la promoción de la salud, han utilizado sus propias teorías y sus métodos de investigación para realizar estudios sobre las diversas prácticas que se asocian a la promoción de la salud. Aunque la investigación en la promoción de la salud ha adquirido varios atributos de campos diversos, las prácticas de investigación de diferentes perspectivas disciplinares no son suficientes para crear una base de conocimientos coherente para la promoción de la salud.
Planteamos tres dimensiones para continuar estructurando la promoción de la salud. La primera tiene que ver con el objeto para el cual se produce el conocimiento, que en el caso de la investigación en la promoción de la salud, se refiere a las prácticas sociales de salud. La segunda dimensión está relacionada con el propósito y la ética de la investigación. En cuanto a la investigación en la promoción de la salud, esta persigue el doble fin de producir conocimiento (propósito epistémico) y de contribuir al cambio social (propósito transformativo). La tercera implica el conocimiento producido y las condiciones para un conocimiento válido que, en la investigación en la promoción de la salud deberían incluir identificar la complejidad de la práctica social y el diálogo esencial entre científicos. Fieles a los propósitos de la promoción de la salud, proponemos un proceso ascendente para estructurar el campo a través de la creación de un *Global Handbook of Health Promotion Research*, que se basaría en las prácticas de investigación de quienes están involucrados en la investigación en la promoción de la salud. (Global Health Promotion, 2021; 28(4): 26–35)

Fortalecimiento de la práctica de la promoción de la salud: desarrollo de capacidades en un campo transdiciplinario

Stephan Van den Broucke

La creciente carga de las enfermedades no transmisibles y de las recientes enfermedades transmisibles emergentes, la multimorbilidad, el incremento de las inequidades en salud, los efectos del cambio climático y de los desastres naturales en la salud y la revolución en la tecnología de la comunicación requieren un cambio de enfoque hacia servicios de salud más preventivos, centrados en las personas y basados en la comunidad. Dicho cambio trae repercusiones para el personal de la salud, que necesita desarrollar nuevas capacidades y habilidades, muchas de las cuales son el núcleo de la promoción de la salud. Así, la promoción de la salud está siendo integrada a la salud pública moderna, lo cual implica tanto oportunidades como desafíos para la promoción de la salud. Una mayor atención a los facilitadores de la salud realza la importancia estratégica del enfoque de la promoción de la salud en toda la sociedad, destaca los logros de la promoción de la salud con respecto a las competencias profesionales básicas y ayuda a formar la capacidad en salud pública con énfasis en promoción de la salud. De otro lado, integrar la promoción de la salud puede debilitar su capacidad organizacional y su visibilidad y la pone en riesgo de ser absorbida en un discurso tradicional de salud pública, dominado por las profesiones médicas. Para enfrentar estos desafíos y aprovechar las oportunidades, es importante que el personal de promoción de la salud se posicione en el terreno de la diversificación de la atención primaria y la salud pública. Al tomar como puntos de referencia el estatus transdiciplinario de la

promoción de la salud y sus sistemas de desarrollo de capacidad en prevención y promoción de la salud primaria y secundaria, este artículo considera las posibilidades de integrar e implementar las capacidades de la promoción de la salud dentro y fuera de las fronteras disciplinares, y sostiene que la contribución de la promoción de la salud al desarrollo de la salud pública radica en el carácter complementario de una promoción de la salud especializada e integrada. (Global Health Promotion, 2021; 28(4): 36–45)

Sistema de Acreditación de Promoción de la Salud de la UIPES – desarrollar y mantener una fuerza laboral competente para la promoción de la salud

Barbara Battel-Kirk, Shu-Ti Chiou, Liane Comeau, Ronan Dillon, Kirsten Doherty, Andrew Jones-Roberts, Tia Lockwood, Marguerite Claire Sendall, Viv Speller y Margaret M. Barry

Este comentario presenta el desarrollo y la implementación del Sistema de Acreditación de la UIPES basado en las competencias en el contexto de la capacidad de la fuerza laboral como una actividad clave de la Unión Internacional de Promoción de la Salud y Educación para la Salud (UIPES). Se describe el proceso de desarrollo de este Sistema, la forma en que se basa y aporta a la investigación y a la experiencia internacionales en enfoques de promoción de la salud basados en competencias. Se presenta una visión general de cómo funciona el Sistema, su estatus actual y sus planes futuros. Se considera también la evidencia del impacto positivo del Sistema hasta la fecha, en particular dentro del contexto de la educación en promoción de la salud. (Global Health Promotion, 2021; 28(4): 46–50)

De la educación para la salud al alfabetismo electrónico para la salud – construir sobre el pasado para darle forma al futuro

Don Nutbeam

La educación para la salud ha evolucionado continuamente y ha tomado varias formas distintivas con el paso de las décadas. El surgimiento de nuevos conceptos como la promoción de la salud y el alfabetismo para la salud ayuda a moldear y refinar nuestra comprensión de cómo el propósito, el contenido y los métodos de la educación para la salud pueden adaptarse a los nuevos enfoques y prioridades de la salud pública. Considerar la educación para la salud a través de la lente del alfabetismo para la salud ha sido particularmente útil para marcar la diferencia entre la educación para la salud tradicionalmente enfocada en la tarea y la educación para la salud enfocada en las capacidades, diseñada para desarrollar más habilidades genéricas y transferibles. La llegada de los medios electrónicos ha facilitado un acceso sin precedentes a la información sobre salud, pero trajo con ella nuevos desafíos. Administrar el volumen de información disponible y evaluar su calidad y veracidad se han convertido en competencias esenciales del alfabetismo para la salud en la era de la información. Como educadores para la salud, necesitamos continuar adaptando nuestras prácticas a estas nuevas oportunidades y comprender los desafíos que llegan con ellas. (Global Health Promotion, 2021; 28(4): 51–55)

Visualización del futuro de la promoción de la salud

Ilona Kickbusch

La COVID-19 nos ha mostrado plenamente que el mundo puede comprometerse con un enfoque transformador que promueva la salud y el bienestar. Vivir en el Antropoceno –un periodo definido por el impacto humano en nuestro ecosistema– nos lleva a un terreno desconocido. El reto es encontrar un modo de vida cuyo objetivo sea satisfacer las necesidades de todas las personas conforme a los recursos de un planeta vivo. Necesitaremos visión, agilidad y resiliencia para estar bien preparados. Los riesgos mundiales a los que nos enfrentamos son enormes y están interconectados; sin embargo, la oportunidad para acelerar el cambio y mejorar también es extraordinaria. Tenemos modelos, conocimiento y tecnologías a nuestra disposición que

mejorarían significativamente la salud y el bienestar y crearían sociedades más justas y sostenibles, pero que no han sido utilizados ampliamente para satisfacer los propósitos públicos y hacerles frente a las inequidades. (Global Health Promotion, 2021; 28(4): 56–63)

¿Cómo la promoción de la salud puede alejar a los humanos del borde del desastre?

Fran Baum

La promoción de la salud ha evolucionado durante las últimas décadas, de un enfoque primario en el cambio de comportamientos a establecer un objetivo ambicioso de crear ambientes saludables, justos y sostenibles de manera que se respeten los derechos de todas las personas a la salud y al bienestar al tiempo que se protege la salud de nuestro planeta y sus ecosistemas. Este artículo sostiene que para contribuir con dicho objetivo ambicioso, la promoción de la salud debe completar tres tareas claves. La primera es la necesidad de tomar en serio la salud planetaria y alejarse del pensamiento reduccionista para adoptar un enfoque que determine al planeta como un sistema complejo y valore más la armonía con la naturaleza, proteja la biodiversidad y prevenga el calentamiento global.
La segunda tarea es defender y apoyar a los gobiernos que trabajan por la salud. La clave para lograr esto es poner la salud y la equidad por encima del lucro, creando ambientes urbanos saludables, alentando la toma de decisiones participativa, promoviendo los modelos económicos saludables y evaluando la forma como actúan los determinantes corporativos de la salud. La tercera tarea es garantizar que las iniciativas para profesionalizar la promoción de la salud no se realicen a expensas de la promoción de la salud para personas y organizaciones poderosas. La promoción de la salud está bien ubicada para apoyar los movimientos de la sociedad civil que buscan un cambio social y económico en beneficio de la salud, tales como Las Vidas Negras Importan (Black Lives Matter) y movimientos ambientales. (Global Health Promotion, 2021; 28(4): 64–72)

Waiora: la importancia de la visión del mundo y la espiritualidad indígenas para inspirar y guiar a la Promoción de la Salud Planetaria en el Antropoceno

Sione Tu'itahi, Huti Watson, Richard Egan, Margot Parkes y Trevor Hancock

Vivimos ahora en una nueva época geológica, el Antropoceno –la época de los humanos– y su comienzo coincide con la fundación de la UIPES, hace 70 años. En este artículo, abordamos el cambio fundamental que enfrenta la promoción de la salud en los próximos 70 años, lo cual nos lleva casi hasta el 2100: ¿Cómo conseguimos la salud planetaria? Comenzamos con una breve sinopsis de los rápidos y masivos cambios globales ecológicos a los que nos enfrentamos, las fuerzas sociales, económicas y tecnológicas que impulsan estos cambios y sus implicaciones para la salud. Sin embargo, en el centro de estas fuerzas motrices se encuentra un conjunto de valores básicos que son incompatibles con la salud planetaria. El eje de nuestro argumento es la necesidad de un nuevo conjunto de valores que acaten y privilegien la sabiduría de la visión indígena del mundo, así como un renovado sentido de la espiritualidad que pueda reestablecer la reverencia hacia la naturaleza. Proponemos un marco basado en el conocimiento indígena para inspirar e informar a la que llamamos la promoción de la salud planetaria, con el fin de que, como escribió recientemente el Secretario General de la ONU, podamos hacer las paces con la naturaleza. (Global Health Promotion, 2021; 28(4): 73–82)

People-Planet-Health: promover los movimientos de base mediante una coproducción participativa

Claudia Meier Magistretti, Jake Sallaway-Costello, Shadhaab Fatima y Rachel Hartnoll

La amenaza del cambio climático antropogénico requiere una acción inmediata para prevenir perjuicios mayores a la salud humana y a los ecosistemas naturales vulnerables. Este proceso de cambio pudo haber

comenzado localmente, liderado por organizaciones de base alrededor del mundo. Al concebir sus acciones como una forma de salutogénesis, estas organizaciones crean un Sentido de Coherencia para empoderar a las comunidades a participar en el desafío potencialmente abrumador de la salud planetaria. El objetivo de People-Planet-Health es darles voz y visibilidad a estos grupos y a sus acciones. Quienes colaboran con el proyecto fueron invitados a crear una declaración de posición conjunta que sirve de base a la estrategia mundial de la OMS sobre Promoción de la Salud.(Global Health Promotion, 2021; 28(4): 83–87)

Replanteamiento de la promoción de la salud: pensar y actuar salutogénicamente hacia la equidad para las comunidades históricamente resilientes

Fungisai Gwanzura Ottemöller, Tulani Francis L. Matenga, J. Hope Corbin, Humaira Nakhuda, Peter Delobelle, Christa Ayele, Nikita Boston-Fisher, Stephanie Leitch, Josette Wicker y Oliver Mweemba

Este artículo explora cómo la teoría salutogénica puede permitirnos replantear el trabajo de la promoción de la salud con las comunidades marginadas hacia un enfoque que reconozca y valore su resiliencia. Utilizamos los tres conceptos clave en el modelo de salud salutogénico de Antonovsky – sentido de coherencia, recursos generales de resistencia y recursos específicos de resistencia – para explorar la relevancia de la teoría para la equidad en salud y presentar, de este modo, nuevas oportunidades para reevaluar radicalmente los enfoques actuales de la promoción de la salud. Concluimos que una promoción de la salud más equitativa requiere una mayor participación de las comunidades marginadas en la definición de su futuro y sugiere un nuevo modelo para la históricamente fundamentada promoción de la salud salutogénica.(Global Health Promotion, 2021; 28(4): 88–96)

Alcanzar los ODS y enfrentar las emergencias de salud en África: fortalezas de la promoción de la salud

Davison Munodawafa, Handsome Onya, Mary Amuyunzu-Nyamongo, Oliver Mweemba, Peter Phori y Aminata Kobie

En 1986, la Organización Mundial de la Salud (OMS) convocó la primera Conferencia Mundial sobre Promoción de la Salud, que se realizó en Ottawa (Canadá). De esta Conferencia surgió la Carta de Ottawa, que define la Promoción de la Salud como el proceso que permite a las personas incrementar el control sobre su salud y mejorarla. Se realizaron después otras reuniones, como la 6ª Conferencia Mundial en Bangkok (Tailandia), convocada por la OMS en el 2005, que dio como resultado la Carta de Bangkok para la Promoción de la Salud. Este documento expandió por primera vez la función de la promoción de la salud para abordar los determinantes sociales de la salud. Posteriormente, en el 2012, los ministros de Salud de 47 países de la Oficina Regional de la OMS para África respaldaron el documento Promoción de la Salud: Estrategia para la Región Africana. Esta Estrategia contempla ocho intervenciones prioritarias, necesarias para enfrentar los factores de riesgo para la salud y sus determinantes. En el 2011, ministros de Salud y grupos de la sociedad civil adoptaron la Declaración Política de Río sobre Determinantes Sociales de la Salud para abordar las inequidades y desigualdades dentro y entre poblaciones. En ella plantearon áreas de acción relacionadas con mejorar la gobernanza para abordar las causas fundamentales de las inequidades en salud, fomentar la participación y la implicación, impulsar el liderazgo comunitario para ejercer acciones con respecto a los determinantes sociales, hacer un llamado a la acción mundial sobre los determinantes sociales para alinear las prioridades con las partes interesadas, y monitorear el progreso en la implementación de políticas y estrategias. La promoción de la salud ha sido fundamental en la respuesta a brotes de enfermedades como el Ébola y la COVID-19. Ha sido también parte integral en la reducción de la mortalidad y la morbilidad materna e infantil, así como TB, VIH/sida, y malaria, y,

últimamente, para reducir el impacto de las enfermedades no transmisibles como la diabetes, la hipertensión y el cáncer. Mientras los desafíos continúan fortaleciendo la promoción de la salud, se han dado esfuerzos concertados para ubicar a la promoción de la salud en la agenda de desarrollo de los países a través de Salud en Todas las Políticas, el fortalecimiento de las capacidades, el monitoreo y la evaluación, y opciones innovadoras de política financiera utilizando los impuestos provenientes del cigarrillo y el alcohol o de la circulación.(Global Health Promotion, 2021; 28(4): 97–103)

Redefinir la promoción de la salud para alcanzar lo inalcanzable: oportunidades para el cambio transformativo en el Sur y el Sureste Asiático

Alok Mukhopadhyay y Nancepreet Kaur

La pandemia expuso la vulnerabilidad de nuestra civilización y reforzó la importancia de vivir en armonía con la naturaleza sin arrasarla de manera concurrente. El Sur y el Sureste Asiático deben desempeñar una función vital para alcanzar el objetivo de 'Salud para Todos', dado que tienen una proporción significativamente grande del ingreso mundial y de pobreza multidimensional, comparadas con otras regiones. Claramente, el progreso en los resultados de salud y desarrollo de estas regiones no se puede lograr sin considerar los determinantes sociales de la salud y garantizar una participación pública activa. Estas regiones deben abordar de manera colectiva los determinantes sociales de la salud siguiendo un modelo de promoción de la salud realista. Este es, en efecto, el momento favorable para mirar más allá del llamado modelo reduccionista biomédico de atención en salud hacia un modelo más holístico de salud, que ponga a los humanos y al medio ambiente en el centro y enfatice en la importancia de promover la salud y el bienestar. (Global Health Promotion, 2021; 28(4): 104–108)

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