

**"The Ottawa and Bangkok Charters: from Principles to Action"**  
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**Summary of talk by**

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**Some background to the Ottawa Charter:**

The decade of the 1970s reveals the precursors of the thinking represented in the Ottawa Charter. For example, in the U.S. the concept of "health promotion," expressed in the "California Syndrome," as well as by "American Narcissism," focused on healthy lifestyles. A plethora of theories and strategies exploded on the landscape for improving and maintaining health through nutrition, meditation and exercise.

In the same decade, a movement grew to promote lay power in health care. Strands of this movement included encouraging self-care (in diagnosis and treatment), mutual aid groups (e.g., Self-Help Mutual Aid International), networking and social support, all with the goal of improving health. The idea of social capital to advance health, or health assets, began to gain attention. Concomitantly, efforts were made in formal health care services to "humanize" primary care.

But, most significant here was the growing recognition of the social and economic determinants of health, the need for strengthening community action, the role of social activism, and the key, but heretofore neglected, role of intersectoral collaboration of public health and other policy areas to improve health.

The 1970s and 1980s were chaotic years, characterized by a surge in new options, opportunities and tensions between behavior change enthusiasts and those who emphasized structural change. The Declaration of Alma-Ata in 1978 clearly stated the central place of primary health, public participation and intersectoral collaboration for future work. Further, the appearance of AIDS; issues of women's health and gender equity; social/economic, and therefore, health, inequalities; and the overarching reality of vast poverty were seen with new urgency.

**The Ottawa Charter, 1986:**

In 1986, conversations began at the WHO/EURO program in health education and health promotion. It was seen as critical to bring together, in some sort of Declaration or Proclamation or Agreement, the disparate movements in health promotion, or at least, to map their collective contribution to health promotion.

From November 17 to 21, precisely 20 years ago to the day, a meeting of 29 countries' representatives was held in Ottawa, graciously hosted by the Canadian government. The goal was to write a "Charter," a statement that would be significant and full of hope, but less directive than a "Proclamation." Most of the participants (signators) represented developed, industrialized countries of Europe and North America—which later turned out to be a significant limitation.

I can tell you that this was a wild and exhausting week of definitional and conceptual debate, as you could expect from a group representing a wide range of cultures, philosophical positions, and approaches to promoting health. There were times when some of us were ready to give up the search for a conciliatory, compatible, mutually supportive, clear and challenging road map for health promotion. But we reached it together.

The five actions called for by the Ottawa Charter for Health Promotion were to:

- Develop personal skills
  - Strengthen community action
  - Create supportive environments
  - Reorient health services
  - Build healthy public policies
- All through *enabling, mediating, advocating*.

### **What has taken place in the 20 years since the Ottawa Charter?**

The Ottawa Charter has served as a powerful stimulus to integrated, or at least compatible, approaches to developments in promoting health. Since the Ottawa Charter, the goals, priorities and functions of public health itself—philosophically, conceptually, strategically, operationally, and ethnically, have become the basis for the *New Public Health*. Now, on the 20<sup>th</sup> anniversary of the Charter, we can clearly see its positive impact on efforts to promote health, and some unanticipated shortfalls as well.

Among the major positive contributions resulting from the Charter are:

- Our seeing more clearly what and how various categories of interventions fit together. The five basic “components” of the Charter were a strategic *tour de force*.
- The primary and still emerging recognition of the primacy of “building healthy public policy,” supported by the Investment for Health strategy.
- The “socialization” of the development process in health as a popular, social movement in the context of social and economic development—that is, the contributions of health investments to economic and social development, and the contributions of economic and social development to health. (Examples of “conditional cash transfer” programs in Mexico, Brazil, Colombia, and Nicaragua are illustrative.)
- Our gaining respect for the reality and value of community (non-professional) health assets.
- Efforts to understand and introduce approaches and mechanisms for creating health equity (the reduction of health disparities).

World developments have also challenged the Charter’s utility. Now there is the need to make adjustments in the Charter to address contemporary conditions. Such changes that call for a reinterpretation and restatement of the Charter are:

- Globalization (the local/global—“*Glocal*” overlap)
- Communication revolution, and its potential for rapid response, sharing world knowledge and building a global village
- Environmental imperatives demanding a global response
- The stressful dynamic between sensitivity to cultural differences (cultural relativism) and setting global value standards
- The requirement of a democratic context for the Charter to be effective
- Genocide and war (including nuclear threat)
- Religious conflicts

**And tomorrow. . . ?**

We need to redefine the structure/function of global leadership in health, looking toward helping WHO face the 21<sup>st</sup> century. The Ottawa Charter can be redefined to incorporate the perspectives of many not included in 1986: the developing world. Charter revisions can reflect a wider range of cultural viewpoints regarding the definition of health and means for achieving it. That is, a broadened and sustained global voice must be heard to define and redefine health goals and the roles of multiple social, economic and environmental sectors.

The future calls for increasing the capacity for public health leadership at local, state/regional, and national levels to encourage all public policy sectors to perceive the potential (positive and negative) health implications of their policies and programs, and to advise them in identifying health investment opportunities within their remits. Through these actions, the capacity for intersectoral collaborations for health investment can be strengthened. These approaches form the basis for building more equitable strategies for sharing the benefits of development.