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Is the Ottawa Charter still relevant? A survey among Health Promotion practitioners and researchers

Master Thesis

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FOREWORD

The author would like to express her gratitude to first supervisor Dr. Christine Faerber and second supervisor Dr. Christiane Stock for their patience, expertise, and valuable direction while overseeing and reviewing the development and completion of the master thesis.

An eternal Thank You to my wonderful husband Alexander Wilberg for his relentless support and encouragement and for believing in me and this project. Thank you to my parents Jan and Bozena Milczarski and especially Dad for helping with childcare across the world and making this possible. Any success that is mine we share together and I am more grateful than you will ever know.

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ABSTRACT

The Ottawa Charter for Health Promotion celebrated its thirtieth anniversary in November 2016, stimulating discussion regarding the guiding principles of the Ottawa Charter and the progress of health promotion. This study explores the opinions of health promotion researchers and practitioners on the current relevance and application of health promotion principles based on the Ottawa Charter. Four research questions shape this inquiry which include: What is the Ottawa Charter and Health Promotion? What progress and changes have occurred globally and within Health Promotion since the Charter was introduced, how the Charter and Health Promotion concepts and practices been applied and Is the Charter known and still relevant in today's context and where does Health Promotion stand?

An invitation to survey participation was sent to members of the EUPHA Health Promotion section. A total of 193 members (67% females) from 26 European countries responded. Demographic and professional information was collected, and responses addressed the relevance, strengths and weaknesses of health promotion. Respondents rated the use of the five action areas of the Ottawa Charter in their geographic region as well as the perceived progress and value of Health Promotion. Qualitative inquiry explored the reasons for various ratings by identifying meaningful units in participant responses, developing various categories according to their meaning, and organizing these into five central themes addressing the overall research questions.

44% of respondents stated that Health Promotion is well developed in their country and 50% of participants declared the same for Europe. The percentage of use (regularly/very often) of the five action areas in one´s country was rated highest for "Developing personal skills and knowledge" at 64%, followed by "Developing healthy public policy" at 44%, and lowest for "Reorientation of health services" with 31%. Health promotion was rated as a necessary field by 73% of respondents and 5 core themes organizing various categories emerged: Concept, Practice, Impact, Potential and Barriers. Though Health Promotion was perceived to embrace positive vision and values and promote social responsibility for health with various health and social benefits, it is at times an unclear concept with various professional and academic concerns and low awareness in the professional and public sphere. Though HP demonstrates great potential for individuals and communities and holds good intentions that demand action, challenges include permeating social, political and investment barriers, competing interests and lack of intersectionality, the perceived dominance of curative/disease oriented perspectives, lack of immediate outcomes and evidence and over-reliance on individual behaviour change.

Though 80% of respondents felt that overall knowledge of health promotion has somewhat progressed, 80% felt that Health Promotion is due for a deeper reflection. Strategies to apply the five action areas in various countries and putting principles into practice may be beneficial, as well as systematically addressing professional concerns regarding perceived weaknesses, threats and challenges influencing Health Promotion.

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1 INTRODUCTION

1.1 THE OTTAWA CHARTER FOR HEALTH PROMOTION

The Ottawa Charter for Health Promotion, sub-titled "The Move Towards a New Public Health," has been identified as an influential and guiding document and tool (IUHPE & CCHE, 2007; McQueen, 2016; Baum & Sanders, 2011) responsible for laying a foundation for Health Promotion theory and practice (IUHPE & CCHE, 2007; Nutbeam, 2005; WHO Secretariat, 2015) and broadening its outcomes beyond the absence of disease (Laverack & Mohammadi, 2011). Since its inception at the First International WHO Conference on Health Promotion in Ottawa, Canada in November 1986 (WHO, 1986), it has sparked the conceptualization, development, discourse, and integration of Health Promotion while inspiring professionals, politicians, and citizens worldwide (Dooris, 2013), giving health promoters a sense of identity (Pettersson, 2011) and adopting a 'Holy Grail' status (McPhail-Bell, Fredericks &Brough, 2013).

The Charter provided a strong, holistic vision highlighting interdependency (Porter, 2006) while describing health as a resource for everyday living and health promotion as "the process of enabling people to increase control over, and to improve, their health" (WHO, 1986). The Charter also emphasized that "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO, 1986) paving the way for the settings approach to health promotion (Dooris, 2013) and an "active and interactive" comprehension of health (Kickbusch, 2007). The Ottawa Charter also highlighted prerequisites for health which included: peace, a stable ecosystem, social justice and equity, resources such as education, food and income (WHO, 1986b) and "aimed to make the healthy choices the easy choices" (Baum & Sanders, 2011).

Health promoters were presented with various roles and functions which were delineated in the Charter (advocating, enabling and mediating) and recommended five action areas, which at the time of publication, were awaited but also considered quite radical (Scriven & Speller, 2007). Areas considered essential for public health action (Kickbusch, 2007) included: healthy public policies, supportive environments, personal skills, community action and reorientation of health services (WHO, 1986). The purpose of health promotion was to amalgamate the old public health with a commitment to the new public health, thus creating a synergy between a social determinants approach (old) and individual and community empowerment (Kickbusch, 2007). Social determinants of health are seen as the circumstances in which individuals are born, develop, work, age (Commission on Social Determinants of Health, 2008) while Empowerment is a term that refers the "ownership and control of their own endeavors and destinies (WHO, 1983) and has been viewed as the heart of community action which sets priorities and implements strategies conducive to population health (WHO, 1983).

Ottawa's vision focused on establishing the norm of partnerships between multiple sectors, upstream measures (addressing fundamental influences on poor health and injustices (Bharmal, Devose, Felician & Weden, 2015)) and the engagement and participation of individuals and communities in decisions around their health and wellbeing (Scriven & Speller, 2007). Use of the charter also targeted health inequalities and other broader determinants, highlighted the social model of health, and connected the goal of health with the modification of various political, economic, environmental and social factors in order to globally and locally shape the public health agenda (Scriven, 2005).

Over 30 years later, discourse around the Ottawa Charter and Health Promotion continues to circulate within Public Health and beyond. The challenges and new obstacles that have arisen since Ottawa have prompted initiation of the "Vienna Declaration" which strives to renew the dedication to the principles of the Ottawa Charter for Health Promotion by reviewing, updating and expanding on the prerequisites of health, functions and action areas (EUPHA, 2016). The declaration "calls on all parts of the public health community, in Europe and beyond, working at all levels, local, national, regional and global, to recognize the multi-tiered determinants of health and opportunities for action" (EUPHA, 2016). Though movement towards such action has recently been initiated within the public health community, exploring the opinions of health professionals working within it is well warranted. The purpose of this study is to raise questions, both practical and theoretical, to assess the Ottawa Charter, its relevance and use for Health Promotion today, and the operational functions of Health Promotion concepts and practices since the introduction of the Ottawa Charter. Key issues addressed through such inquiry include:

- What is the Ottawa Charter and Health Promotion?
- What progress and changes have occurred globally and within the Health Promotion field since the Charter has been introduced?
- How have the Charter and Health Promotion concepts and practices been applied?
- Is the Charter known and still relevant in today's context and where does Health Promotion stand?

A critical reflection and discussion is necessary to solidify a vision, and shape the next 30 years for future health promoters with the assurance of practical strategies for a variety of diverse contexts.

2 CONTENT CHAPTER OTTAWA CHARTER IN THE CONTEXT OF ITS HISTORY AND DEVELOPMENT

2.1 DEVELOPMENT OF THE OTTAWA CHARTER

Though the roots of health promotion are multifaceted, the global WHO meeting at Alma Ata, Kazak in 1978 (WHO, 1978) is seen as a shifting point as Primary Health Care was formally embraced as the main driver for the delivery of health care (Catford, 2011). This stimulated a transferal of power to the broader community and health service consumers (Catford, 2011). In 1981, WHO prepared goals and targets in their

global strategy *Health for All by the Year 2000* (WHO, 1981) which further heralded Health Promotion developments (Catford, 2011). A series of events trailed that became a stepping stone to launch the Ottawa Conference and Charter (WHO 1986a, b, c): emergence of the social concept of health education and lifestyles approaches (Kickbusch, 1981; WHO, 1983), *The Concepts and Principles of Health Promotion* document published in the preliminary edition of *Health promotion International (WHO, 1984),* a health promotion policy framework (WHO 1986a, b, c) and a Health Promotion terms glossary translated in 5 languages (Nutbeam, 1986; Catford, 2011).

In November 1986, the Canadian Government and Public Health Association of Canada collaborated with WHO to facilitate the Ottawa conference (WHO, 1986a) which connected 212 representatives from 38 countries, legitimized preceding developments including *Health for All*, produced the Ottawa Charter, created the health promotion logo, and was considered as the birthplace of the health promotion movement and catalyst to global health development (Catford, 2011). The Charter that blossomed had established and endorsed various prerequisites for health (WHO 1986b) and "highlighted the role of organizations, systems and communities, as well as individual behaviors and capacities, in creating choices and better opportunities for health" (Catford, 2011).

2.2 KEY CONTRIBUTIONS TO HEALTH PROMOTION

The Charter continued to provoke inspiration for subsequent articles, documents, charters, and conferences internationally (McQueen, 2016) facilitating action in numerous countries (Catford, 2011). Several global conferences followed and built on Ottawa's 1986 publication (Nutbeam, 2008), as highlighted in *Figure 1*. Though conferences stimulated great energy and were a source of sustenance for Health Promotion, accomplishments from conferences were also criticized as insufficiently applied (Pettersson, 2011).

Document	Main Message
Declaration of Alma-Ata on Primary Health Care (WHO, 1978)	Officially assumed Primary Health Care as guiding means to deliver health-care. Spurred WHO's development of global strategy (WHO, 1981) *Health for All by the Year 2000* (Catford, 2011, WHO, 2009)
Ottawa Charter for Health Promotion (WHO,1986)	Solidified vision of HP and pursuit of Health for All by introducing central concepts, prerequisites for health, and roles for health promoters and action areas (Catford, 2011, WHO, 2009).
Adelaide Recommendations on Healthy Public Policy (WHO, 1988)	Building healthy public policy as central focus. Called for political commitment to health, consider political decisions on health, augment political investment in health (Catford, 2011, WHO, 2009)
Sundsvall Statement on Supportive Environments for Health (WHO, 1991)	Creating supportive environments as central focus. Emphasized importance of individuals and communities as driving forces for sustainable developments (Catford, 2011, WHO, 2009)
Jakarta Declaration on Leading Health Promotion into the 21st Century (WHO, 1997)	5 priorities identified after review of the Ottawa Charter. Focus on emerging global challenges and presenting evidence of HP effectiveness (Catford, 2011; WHO, 2009).
Mexico Ministerial Statement for the Promotion of Health: From ideas to action (WHO, 2000)	Focus on realizing greater healthy equity between and within countries. Verified HP's role in supporting health actions on local, national and global levels and vowed to facilitate action and progress plans specific to various countries (Catford, 2011; WHO, 2009).
The Bangkok Charter for Health Promotion in a Globalized World (WHO, 2005)	Endorsed Ottawa while adding four new commitments which addressed the management of global influences in relation to health promotion (Catford, 2011; WHO, 2009)
The Nairobi Call to Action (WHO, 2009b)	Focused on pressing concerns deeply reflecting African perspectives including stronger leadership and workforces, normalizing HP, better means for empowerment and participation of communities and people, knowledge development and integration (Catford, 2011)

Figure 1: Health Promotion documents from global conferences (WHO, 2009a)

2.3 HEALTH PROMOTION EMBLEM

The Health Promotion emblem (*Figure 2*), created at the 1st International Health Promotion conference in Ottawa and reinforced at the second and third conferences, represents a graphic interpretation of Health Promotion as described in the Ottawa Charter (WHO, 2009a). The logo presents an outside red circle (the goal of "Building healthy public policies) which illustrates the need for policies to "hold things together" and establishing the environment for the other action areas within the circle (WHO, 2009a). "Strengthening community action" and "Developing personal skills" are in the upper wing which breaks out of the circle. This symbolizes the state of constant flux for people and communities requiring policy to react and act to such transformations (WHO, 2009a). "Creating supportive environments" is reflected in the side middle wing and "Reorienting health services" towards disease prevention and health is in the bottom wing. The round spot inside the circle stands for Health promotion strategies, enabling, mediating and advocating, required to apply the Health promotion action areas (WHO, 2009a).

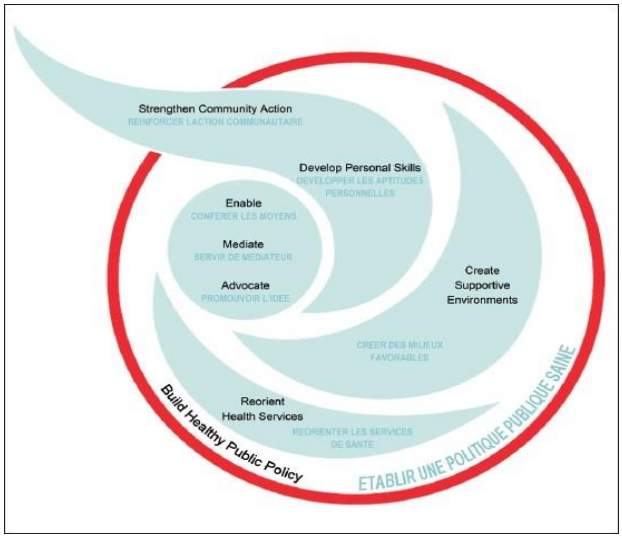

Figure 2: Health Promotion emblem (WHO, 2009a)

At the Jakarta conference, the logo was modified with the inner spot and outside circle connected as well as the wings originating from the inner spot and reaching out of the circle. Modifications were an effort to reflect the significance of multi-strategic approaches, how HP reaches out to society from a local to global level, and to demonstrate how HP has progressed (WHO, 2009a).

2.4 HEALTH PROMOTER ROLES AND FUNCTIONS

Advocating, enabling and mediating are roles required for health promoters to implement key action areas of the Ottawa Charter. Advocacy for health is necessary for ensuring and creating more favourable conditions to facilitate good health and quality of life (WHO, 2009a). Conditions may either challenge or promote good health and strong voices and action is needed to protect conditions when they are resourceful to health and combat them when they are harmful to health potential (WHO, 2009a).

Enabling is a strategy that supports all individuals to achieve their fullest health potential by achieving control over their health requiring: supportive environments, information access, possibilities for enhancing life skills and healthy choices, equal opportunities and resources (WHO, 2009a). Enabling should also aim to reduce differences in health status and between men and women (WHO, 2009a).

Mediating between competing interests in society is required, particularly by health promoters, social and professional groups (WHO, 2009a). Mediation is necessary for coordinated action between people, communities and families, NGO's and voluntary organizations, all sectors in government, media, industries, and local authorities (WHO, 2009a). Mediation must be adapted to fit local, regional and national contexts (WHO, 2009a).

2.5 FIVE KEY ACTION AREAS OF THE CHARTER

The Ottawa Charter identifies five means of action essential for Health Promotion which include: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services (WHO, 2009a).

Building healthy public policy

Health promotion policy involves advocating for and establishing health as political priorities at all levels and sectors, embracing accountability for health and decision-making impacts on health (WHO, 2009a; Ottawa Conference Report, 1986a). Involvement of multiple sectors including education, housing, transportation, environment, communications, childcare and various others (Fry & Zask, 2016), require collaborative and complementary approaches to improve population health, daily conditions of people and communities, as well as fostering social and health equity (WHO, 2009a; Ottawa Conference Report, 1986b; Fry & Zask, 2016). Legislation, taxation, economic measures, methods of organization and operation are government actions required for the removal of obstacles to health and for the creation of simple and accessible pathways allowing healthy choices to be easily made (WHO, 2009a; Ottawa Conference Report, 1986a).

Creating supportive environments

Health Promotion strategies in this area acknowledge the interconnectedness between people and their environment and that people, communities and the environment need to be cared for and protected with unified, mutual action (WHO, 2009a; Ottawa Conference Report, 1986b). Living conditions, leisure, work, educational and other settings can be health resources when organized in a way that cultivates safety, optimal development and wellbeing, refreshment, and inspiration for people and society (WHO, 2009a; Ottawa Conference Report, 1986b). Preservation of the environment requires global action and sustainability is required amidst various fast-paced changes, including but not limited to work, urbanization, production of energy and technology (WHO, 2009a; Ottawa Conference Report, 1986b). Fry and Zask (2016) further state that "physical environments encompass the natural and built environments, and social environments encompass psycho-social, economic and cultural environments".

Strengthening community action

Empowerment of communities is central to strengthening community action, facilitating the possibility for individuals to be more independent and have greater control over their actions, pursuits, and ultimately health determinants (WHO, 2009a; Ottawa Conference Report, 1986c). Health Promotion action develops necessary priorities and strategies through various programs and networks to advocate and enable the

possibility of such ownership, while engaging community resources and strengthening competencies, collaboration, and participation (WHO, 2009a; Ottawa Conference Report, 1986c; Fry & Zask, 2016).

Developing personal skills

Supplying health information, education, and skills for their understanding and use are ways health promoters can care for personal and social growth of individuals and provide options to foster greater choice and control within environments and towards maintenance of health and wellbeing (WHO, 2009a; Ottawa Conference Report, 1986d; Fry & Zask, 2016). Lifelong learning in community settings such as school, home, and work enable preparation and coping with life and health challenges, the ability to assess one's own needs and make necessary changes, and seek appropriate supports (WHO, 2009a; Ottawa Conference Report, 1986d; Fry & Zask, 2016). Health Education and Health Literacy are terms often used when supporting development of personal skills (Fry & Zask, 2016).

Reorienting health services

A health care system which prioritizes health requires the shared responsibility and contributions of people, communities, health professionals, organizations and government (WHO, 2009; Ottawa Conference Report, 1986e). Health promotion requires a shared platform with curative and clinical services in the health sector which relies on attitudinal, organizational, service and structural changes (WHO, 2009; Ottawa Conference Report, 1986e). Health promoting services should highlight a person-centered approach, respect of cultural needs, and require health research and proper education and training of professionals (WHO, 2009; Ottawa Conference Report, 1986e).

2.6 CHARTER ROLES AND RELEVANCE

The role of charters, statements and declarations are to provide a unified vision with documented values for practitioners as well as guiding principles and actions for people, governments and organizations (Leger, 2007). What is said in a charter is to be worthy of constant repetition, serving as a strong reminder of basic priorities and standards for humans, including equity, wellbeing, justice, and access, particularly when at risk for being lost, ignored, or forgotten (Leger, 2007).

The Ottawa Charter has gone through significant developments over the past 30 years and so have innumerable global conditions. Part of the challenge in its application to global problems is that global problems continue to rapidly change and evolve (Sparks, 2013). Ziglio et al. (2011) reinforce that "the Ottawa Charter presents a strategy for creating and promoting health. Therefore, when assessing how well we have done in an action area (i.e. reorienting health services), we need to look at the Charter and its domains as a whole as well as an individual and active domain" (Ziglio et al., 2011). Furthermore, in order to assess the Charter's relevance and steer the future of health promotion, it is essential to analyze the progress

of health promotion, opportunities for Health Promotion, challenges since the Charter's inception, as well as the perspectives of professionals working in the field of Health Promotion, Public health, as well as the general public. The following content chapter 2.0 will present reflections and discourse on the previously mentioned factors.

3 CONTENT CHAPTER OTTAWA CHARTER IN THE CONTEXT OF EXPLORING THE PROGRESS, PRESENT AND FUTURE OF HEALTH PROMOTION

3.1 HEALTH PROMOTION PROGRESS SINCE OTTAWA

The Ottawa Charter's positive influences on the field of Health Promotion can be observed through the various developments in the field since its inception. There has been a swift and persistent expansion of scientific journals, textbooks, and scientific and professional conferences concentrating on health promotion and public health (Pettersson, 2011). With respect to PubMed, the number of scientific articles has doubled every 5 years (Pettersson, 2011) indicating an increasing body of evidence supporting and investigating Health Promotion related principles and interventions. Additionally, Health Promotion is now a subject in various academic institutions and posts across international settings and is continuing in its development (Pettersson, 2011). There has also been growth in various governmental and non-governmental health promotion strategies, foundations, professional associations, and consumer interest groups (Catford, 2011).

Numerous health promoting programs and networks have surfaced on a national and international level since the Ottawa charter which have covered numerous settings: "regions, districts, cities, islands, schools, hospitals, workplaces, prisons, universities, marketplaces" (Dooris, 2006). Implementation of various innovations, many originating and taking place in Europe, have included Health Promoting schools, Healthy Cities, Health Promoting Hospitals and the Investment for Health Approach (Ziglio et al., 2000). These have added significance to the building of knowledge and experience while developing health promotion as a practice in various countries (Ziglio et al., 2000). Positively, Health Promotion activities and research has been quite successful at involving diverse population groups including older and younger people, women and men, individuals with disabilities and chronic illnesses and migrants, among others (WHO 1998b: Ziglio, 2000).

Since Ottawa, tobacco control has been tackled (Wills & Douglas, 2008) with the emergence of the first Public Health Treaty Framework Convention on Tobacco control, among other programs (Sparks, 2013) and the fight continues. Health has become elevated on the political agenda in ways Ottawa could not have anticipated (Kickbusch, 2010) with building momentum for Health in All Policies and a greater health scope in development of policy, especially in Europe and Australia (Sparks, 2013). Attitudinal changes have been slowly moving in the right direction with health inequality being regularly recognized as an issue (Wills & Douglas, 2008) and the progress of mainstreaming social determinants of health and supplementing its case

with increasing evidence and advocacy (Sparks, 2013). Health Promotion energies also play a vital role in guiding UN work on NCDs, ensuring determinants are suitably assessed and not retreating to resolution solely through behaviour interventions (Sparks, 2013).

3.2 OPPORTUNITIES FOR HEALTH PROMOTION

Though progress has been made, great opportunities for health promotion developments still remain. Even with advancements in academics and workforce with regard to health promotion, it is only well-developed in a handful of countries, with complete lack of presence and resources in others (IUHPE & CCHE, 2007). Areas which are well-developed in health promotion need to collaborate better and link with academics and professionals in other fields that implicitly or explicitly promote health including nursing, medicine, psychology, education, developmental sciences and social sciences, among others (IUHPE & CCHE, 2007). Simultaneously, health promotion requires distinct definition as a field and discipline, must lead and communicate its unique body of knowledge and values, possess transnational accordance on its core competencies, and consider recognition through professional accreditation (IUHPE & CCHE, 2007). Clearly defined professional roles in the health sector could allow health promoters to better advocate, mediate and enable; to guide and train health care workers to take greater responsibility for promoting health and lead other disciplines and sectors in doing so (IUHPE & CCHE, 2007). Furthermore, a regulated, credible and visible discipline will likely have more influence in mainstreaming health promotion (IUHPE & CCHE, 2007).

With the vast technological advancements since Ottawa (Nutbeam, 2008; Sparks, 2013; WHO, 1997), health promoters now have the opportunity to strengthen community action, create supportive environments, and develop personal skills online and on social media platforms (Norman, 2012). Individuals and communities can be empowered by such tools (Sparks, 2013) as health promoters can create audiences and enable opportunities for inclusion and participation in the giving and receiving of accurate and accessible knowledge and information, exchange of health messages and potentially producing positive health outcomes (Norman, 2012). It is a globally accessible medium that can aid in information management and facilitate a unified voice (Sparks, 2013) which can be better capitalized on in the field of health promotion.

Responding to complex changes, adapting to copious contexts, applying multiple strategies (Sparks, 2013) are all areas that require greater attention and growth with the acknowledgement of various global challenges that impact health and greater opportunities to address them.

3.3 GLOBAL CHALLENGES SINCE OTTAWA

Since the Ottawa Charter, countless economic and political changes have taken place (Kickbusch, 2011, Nutbeam, 2008), with global societal complexities influencing the undertaking of current and future health challenges (Pettersson, 2011). As a result, fundamental conditions and resources for health (WHO, 1986)

continue to be threatened. This raises concerns regarding how to secure a foundation in the basic prerequisites for health, while simultaneously generating health improvements and equity (WHO, 1986).

Over the past 30 years, the world has faced unexpected "global challenges, pandemic influenza (and outbreaks of infectious diseases), financial crisis and economic downturn, a food crisis, increase in poverty and health inequities in many countries, and climate change" (Ziglio et al., 2011). Currently, both industrialized regions and disadvantaged societies face the rapid spread of infectious diseases and increasing chronic disease burden (IUHPE & CCHE, 2007; Pettersson, 2011).

Globalization has been increasingly impacting lives (Nutbeam, 2008) with transnational corporations challenging equitable health (Baum & Sanders, 2011) by influencing determinants beyond the scope and control of nations, communities, and individuals (IUHPE & CCHE, 2007). The Bangkok Charter attempts to respond to the various global and modern changes and concerns impacting health and wellbeing by further building on the Ottawa Charter (WHO, 2005). However, its discourse has been challenged as propagating such concerns by suggesting ways of coping with globalization without questioning its sources, shifting from ecosocial justice to absorption in law and economics, and "glossing over diversity in people and contexts" (Porter, 2006).

Kickbusch (2011) further highlights forces shaping determinants in the 21st century (Kickbusch, 2008) including (1) unsustainable consumerist patterns and lifestyles resulting in obesity and environmental harm; (2) the flow of people and migration affecting displacement and the accuracy of burden of disease and distribution; (3) "the hurry virus" where urbanization, modern media, new forms of work contributing to lack of time, lack of physical activity, challenged diets, enhanced depression, anxiety, stress in adults and children (Kickbusch, 2011).

3.4 HEALTH PROMOTION SKEPTICISM

The Ottawa Charter for Health Promotion has not been celebrated without criticism. There has been some concern that Health Promotion efforts are short of tackling emerging issues and not sufficiently implemented (Kickbusch, 2012, Nutbeam, 2008), or in some cases, may even induce further inequalities if poorly planned and implemented (Ziglio et al., 2000). There is also concern that activity within health promotion has been "issue based or else focused on one determinant at a time" (Ziglio et al., 2000) resulting in small, minimal adjustments without large-scale effects on policy and health determinants (Ziglio et al., 2000).

Part of the challenge identified with Health promotion is that it is a concept that strongly confronts prevailing hierarchies and structures with power-challenging ideals such as social determinants, participation, equity, and empowerment, therefore time is needed to put due pressure on existing constructs (Pettersson, 2011). As Kickbusch (2010) points out, cycles of innovation may evolve over 30 years, thus remaining steadfast to

health promotion principles is key as opposed to repeatedly reinventing them (Kickbusch, 2010). Additionally, health promotion practice is uniquely complex as "a major part deals with people, social networks, communities and societies at large in dynamic and interacting spirals" (Pettersson, 2011). This complexity deepens as The Ottawa Charter positions that health promotion is not solely the health sector's responsibility, and exceeds the scope of healthy lifestyles to wellbeing (WHO, 2009a). Though widening the responsibility for Health Promotion beyond the health sector has clear benefits, aligns with health promotion values, and certain issues can only be tackled with multi-sectoral action, it has also presented challenges such as competitiveness between government departments, lack of funding or value from the health sector, difficulty in labelling health promotion activities and boundary and role confusion (Scriven & Speller, 2007).

Furthermore, it has been openly acknowledged that the Ottawa conference and its background discourse "focused on the needs in industrialized countries, but took into account similar concerns in all other regions" (WHO, 2009a; Nutbeam, 2008). A raised concern with such focus was the lack of "developing voices" or voices of vulnerable populations who were not part of this discourse (McPhail-Bell et al., 2013) with the conference delegates being selected by invitation only (Porter 2006; McPhail-Bell et al., 2013) and almost exclusively representing developed countries (Porter, 2006).

With lack of balance and input from developing regions, it is unclear how improvement in health can be conceptualized or applied in areas lacking the fundamental resources and prerequisites for health as indicated by the Ottawa Charter which states: "The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites" (WHO, 1986). It is also ambiguous as to how other models of health, such as those reflecting practices and beliefs of indigenous or religious/cultural groups, can be included and illustrated in the Charter (McPhail-Bell et al., 2013) or alternatively, how the Charter impacts those health models, beliefs and practices, and ultimately communities.

Though these origins cannot be changed, and the exact impact of the charter and other declarations is unknown (Leger, 2007), they may be part of an implicit background to some of the challenges within Health Promotion today, specifically in application of Strengthening community action. An identified struggle has been the ability of agencies to build and hold trust of communities, particularly those who are socially marginalized or excluded (Laverack & Mohammad, 2011). Inclusion of more diverse perspectives outside of selective, educated, western-centered views (McPhail-Bell et al., 2013) could evoke greater participation in offering knowledge and experience and enable those who may be at the center of inequalities to be at the center of health promotion action and decision-making (WHO, 2009a). Inclusion in discourse at the onset would have also allowed developing countries and marginalized communities to also discuss how HP practices can impact health, wellbeing and quality of life. Though such roots are irreversible, they should nevertheless be acknowledged and kept in consideration (McPhail-Bell et al., 2013) as a potential limitation of the Charter.

Science and research must also develop more accessible and trusting channels extending beyond the field of health promotion, public health, and the academic and scientific community. Though research is an area where Health promotion has developed extensively since the Ottawa Charter, the language and format of the findings are often inaccessible to individuals outside of the academic community (Pettersson, 2011). A limited audience thus hinders the development of personal skills and knowledge for those seeking relevant and current health related information, and may result in seeking credible and interpretable scientific information elsewhere, including online environments. This is especially true with the expansion of media, internet and mobile communication developments as information and sharing platforms which was unforeseen when the Charter was written (Nutbeam, 2008; Sparks, 2013; WHO, 1997). Though this creates numerous opportunities in today's context as aforementioned, opportunities for alternate sources include poor sources, inaccurately interpreted evidence, and biased social media platforms promoting health myths, among others. These should now be considered and treated as potential threats to Health Literacy and Health Promotion.

The concept of Health Promotion has often been a source of confusion and misinterpretation with the term "Promotion" being associated with advertising or sales (Catford, 2011), the term "Prevention" being either combined with "Health Promotion" or left out and associated with or without prevention of disease (Johansson et al., 2010), and the term "Health Education" being used interchangeably and as an equivalent for HP, rather than a component of "Developing personal skills" (WHO, 2009a). It has also been argued that there is a lack of clear theoretical foundation and framework supporting the Ottawa Charter and its principles (Erikson & Lindstrom, 2008) and suggests that the salutogenic theory should be better integrated in the context and theory base of health promotion research, development and practice (Erikson & Lindstrom, 2008).

There is a permeating critique of the domination of a biomedical approach and curative perspective as well as the push for upstream thinking and greater salutogenic emphasis (Erikson & Lindstrom, 2008). However, there is also a lack of practical and effective guidance to systematically apply collaborative approaches in a variety of settings, including healthcare, in a time where curative values guide present structures and resources (Johansson et al., 2010) and both viral agents and NCD's are on the rise globally (Pettersson, 2012). A study among health professionals in a Swedish health care setting identified barriers to health promotion roles in daily practice including: demanding workload, absence of guidelines, vague objectives, and less positive outlooks to more health promoting services among physicians and men (Johansson et al., 2010). In line with this, the majority of relevant literature is considered to have sufficiently explored the question of "what is health promotion" in an academic and conceptual way, while there is an exceptional lack of implementation research (with only around 5%) explaining "how to do it" in a feasible and practice-oriented manner (Pettersson, 2011), suggesting a redirection in focus for appropriate action in closing the

implementation gap. This is required in various developing and developed settings locally, regionally and nationally to reflect diverse cultural, social, and economic systems (WHO, 2009a)

Finally, while Ottawa's agenda is considered to be well rooted in Health Promotion activity frameworks (Scriven & Speller, 2007), there has been skepticism from others that the Charters framework and basic principles have not been used in formal health promotion programs design and planning models (Fry & Zask, 2016; Goodstadt et al., 2001; Potvin, Gendron, Bilodeau & Chabot, 2005), relevant instruments for its implementation are lacking (Goodstadt et al., 2001), and the Ottawa Charter has not been as well integrated as many had anticipated (Kickbusch, 2007; Hancock, 2011a; Ziglio, 2000, Nutbeam, 2008).

3.5 HOPE FOR HEALTH PROMOTION

Despite its imperfections, the Ottawa Charter has also been affirmed as standing the test of time (Hancock, 2011; IUHPE & CCHE, 2007; Kokeny, 2011) and as relevant today despite global changes (Baum & Sanders, 2011; Pettersson, 2011; Kickbusch, 2011, WHO 2009a) though new responses are required (WHO, 2009a) and must be linked to 21st century determinants of health (Kickbusch, 2011). The Charter acknowledged that "political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it" and advocating, enabling and mediating for health within Health promotion action can create more favorable conditions (WHO, 2009a). Amidst threatening conditions, perspectives persist that relentless promotion and protection of the health of people and communities must be at the heart of health systems (Ziglio et al., 2011) and modern hazards can also be considered as "new challenges and new opportunities to reframe, reposition, and renew efforts to strengthen Health Promotion" (Ziglio et al., 2011).

Various opinions still maintain that strong, continued recommitment to the Ottawa Charter, its principles and its implementation in all countries and regions is still considered necessary (Scriven & Speller, 2007, IUHPE & CCHE, 2007), however an adjustment to Health Promotion approaches and strengthening conditions for its efficiency is required in response to emerging health challenges and fluctuating conditions worldwide (IUHPE & CCHE, 2007).

In light of the 30th anniversary of the Ottawa Charter, this study aims to review the Charter, its contribution to Health Promotion along with developments over the years, and critical questions and discussions surrounding it. A survey is conducted to explore current professional perspectives regarding the Charter's relevance and Health Promotion principles with a specific focus on the five key action areas and their perceived progress and application, particularly in Europe. Exploring such perspectives is pivotal to face current and future challenges to population health and wellbeing in an organized and consistent manner, and to continue to shape health promotion practice and actualize the full potential of its principles and values as represented in the Ottawa Charter. The objectives of the following analysis will therefore integrate

professional opinions to continue to explore what the Ottawa Charter and Health Promotion represents, whether its concepts and principles have or have not been applied, and whether or not it remains valued and relevant today.

Therefore, we ask; is the Ottawa Charter still relevant today? Do the values and principles presented continue to motivate Health Promoters in both social and scientific roles? Does the Charter provide necessary guidance for professionals and population groups to adapt to and act on the innumerable challenges currently faced in diverse contexts? By means of a survey, this study engages the participation of health professionals and promoters in this discourse from various settings and regions. Our aim is to expand viewpoints and further assess perspectives of the Ottawa Charter's relevance today, identify observed progress, opportunities and challenges of HP, and consider the successful application of the Charter's key action areas and potential gaps in implementation. Inviting and assessing diverse perspectives within the field is an essential part of exploring HP in a unified way and planning wisely for paving a brighter, healthier present and future.

4 MATERIALS AND METHODS

4.1 LITERATURE SEARCH

A literature search was conducted on databases of PubMed, Web of Science, Cochrane, Sociological Abstracts in the Unit for Health Promotion Research at the University of Southern Denmark. Key words "Ottawa Charter" and "Health Promotion" were used individually and in combination to retrieve articles.

Additionally, reference lists were scanned for further relevant articles. Only articles in the English language were included, as well as editorials, commentaries and debates. Though focus was given on articles written in the past 12 years, older articles were included if they provided context to health promotion concepts and progress since the Ottawa Charter. Articles were excluded if content lacked specific connection to the Ottawa Charter or focused on health promotion specifically in one country. After the exclusion of duplicates and irrelevant articles through abstract screens, a total of 149 articles were fully screened, and a total of 38 articles were used. Written textbooks were identified and retrieved from libraries of University of Southern Denmark and Hamburg University of Applied Sciences. The flowchart in Figure 3 further highlights the process of article identification and selection.

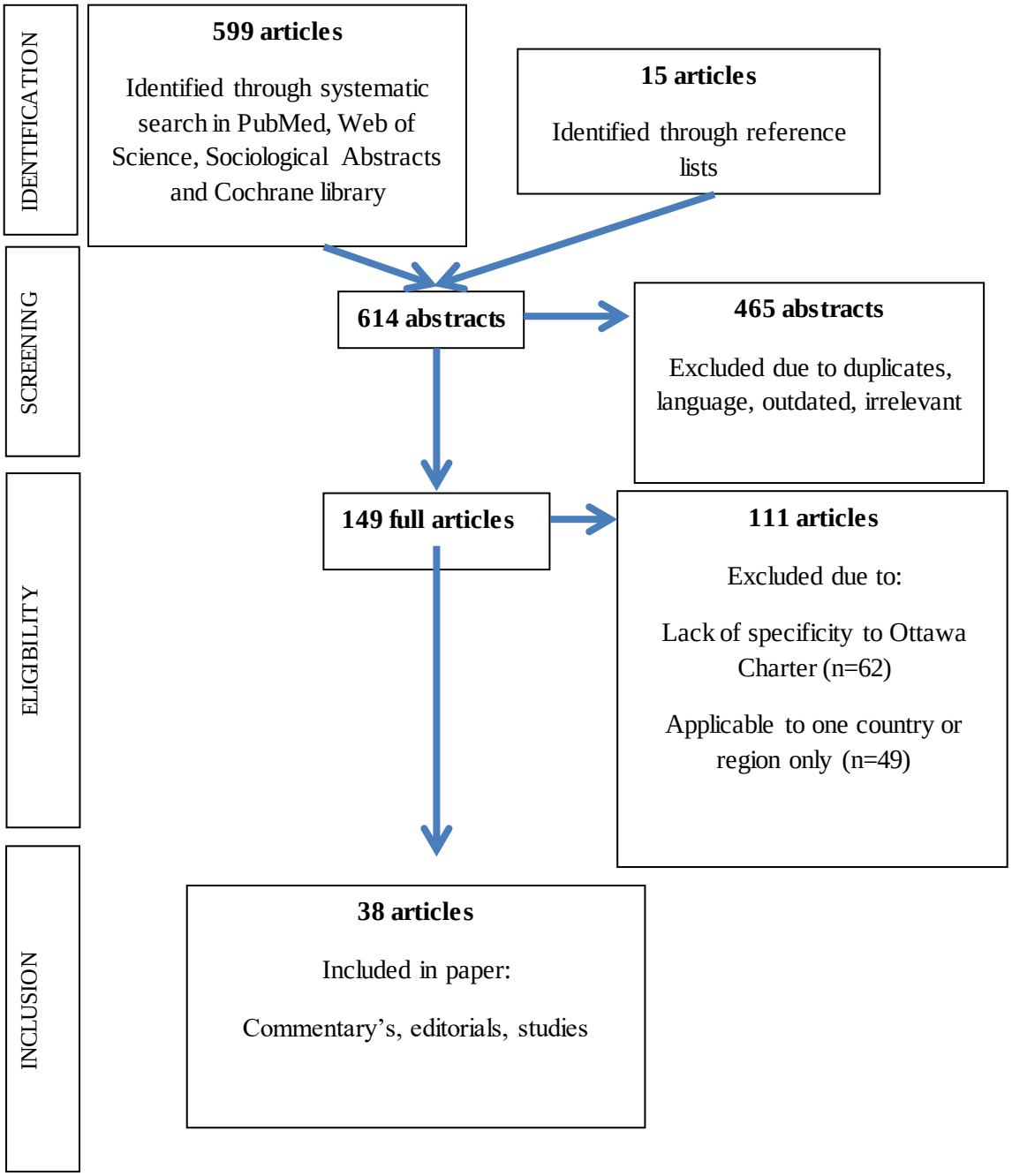

Figure 3: Flow chart for article identification and selection

4.2 SURVEY DESIGN AND DATA COLLECTION

A survey was designed and developed between February and March 2016 and conducted between April and May 2016. A pilot test was executed in March 2016 on the Health Promotion Unit at University of Southern Denmark and adapted to reflect relevant feedback. The first invitation to participate was sent out to EUPHA Health Promotion section members in April 2016, and a reminder invitation was sent in May 2016. Figure 3 presents a flow chart of the study population**.** Answers were collected from 198 participants and data from 193 respondents were included in the analysis. The questionnaire contained a total of 15 questions addressing demographics and self-reports on the relevance of the Ottawa Charter, how well the action areas have been applied in one's country of work, and perspectives on strengths and weaknesses of health promotion.

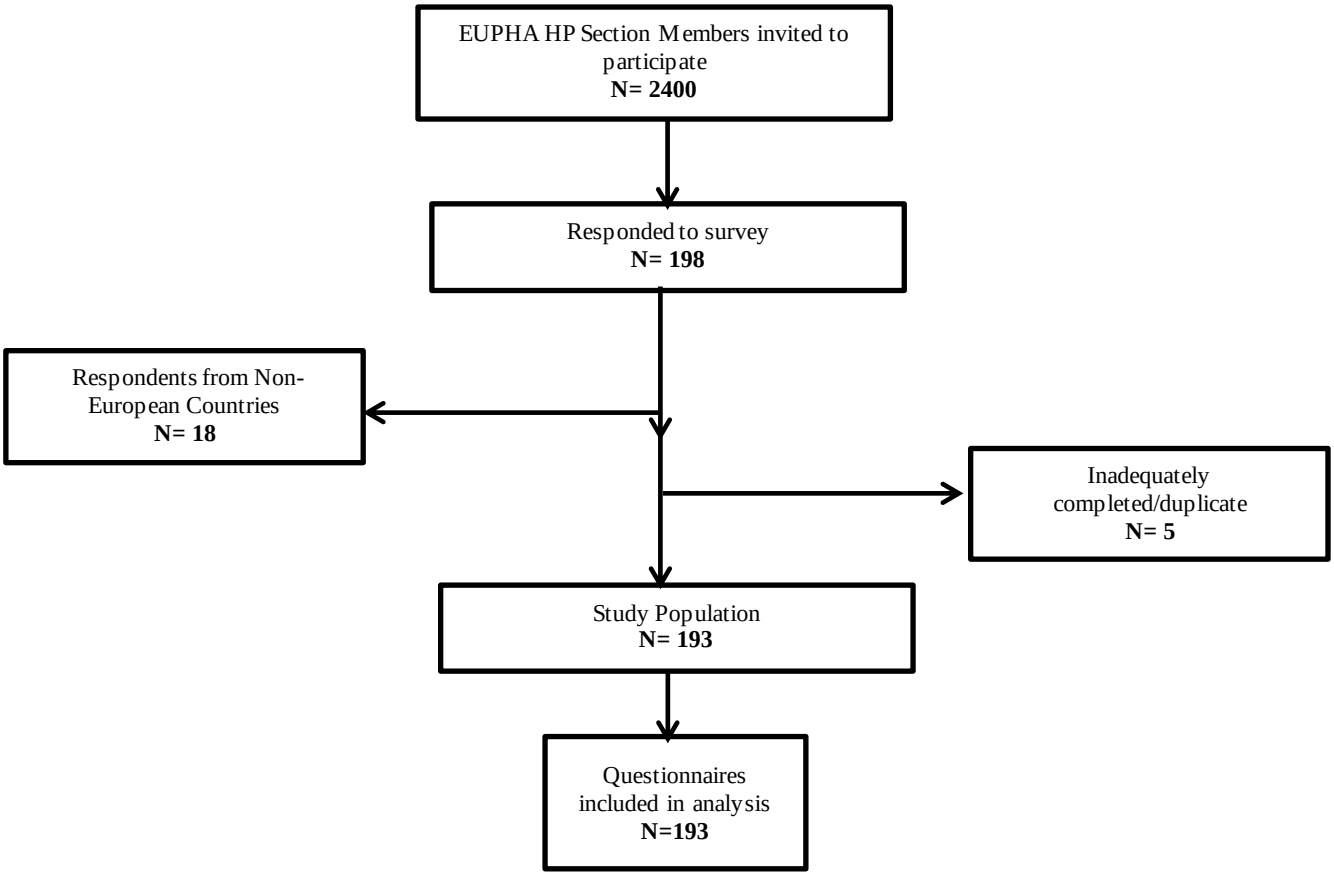

Figure 4: Flowchart of study population

4.3 PROCEDURE

The survey questions were developed by the president and vice president of the EUPHA Health Promotion section and questions covering the actions areas and Health Promotion were guided by the principles of the Ottawa Charter (WHO, 1986). The participants were asked questions related to socio-demographics and professional characteristics including age and gender, one's country of reference for their work as a health professional, and the number of years working in the field of Health Promotion/Public Health. Reference countries were then divided into 6 Global Region's according to WHO (WHO, 2016) while European countries were divided into Northern, Southern, Eastern and Western Europe according to the United Nation's geoscheme for Europe (UN, 2013). The options for most common professional domains in the field were divided into three categories: curative/palliative/prevention care worker, health promotion/public health practitioner or public health administration, researcher or teaching/education.

4.4 PARTICIPANTS

The majority of respondents had between 5-30 years of professional experience in Health Promotion and Public Health, 67% were female, and comprised of 43 different countries (see *Figure 5* and *Figure 6*). With regards to global regions of professional experience, most participants represented Southern Europe (29.51%), Western Europe (25.68%), and Northern Europe (24.59%), particularly Italy and Denmark, with less respondents from Eastern Europe (10.38%). Respondents from other global regions such as African (1.1%), Eastern Mediterranean (1.64%), South-East Asia (0.55%), The Americas (3.83%), Western Pacific (1.64%) and Global representation (1.09%) were placed in the *Other* category. The majority of respondents were in the professional domain (see *Figure 7)* of Research and/or Teaching (52.85%), followed by Health promotion/public health practitioner/public health administration (37.31%), and Curative/palliative/prevention worker (9.33%)

	F	%
Professional domain:		
Curative/Palliative/Prevention worker	19	9.84%
Health promotion/Public health practitioner, or Public health administration	72	37.31%
Researcher and/or Teaching/Education	**102**	**52.85%**
Total		100.0%
Length of time working in Public Health:		
< 5 years	29	15.03%
5-15 years	66	34.20%
16-30 years	**75**	**38.86%**
>30 years	23	11.92%
Total		100.0%

Figure 5: Table of Professional characteristics

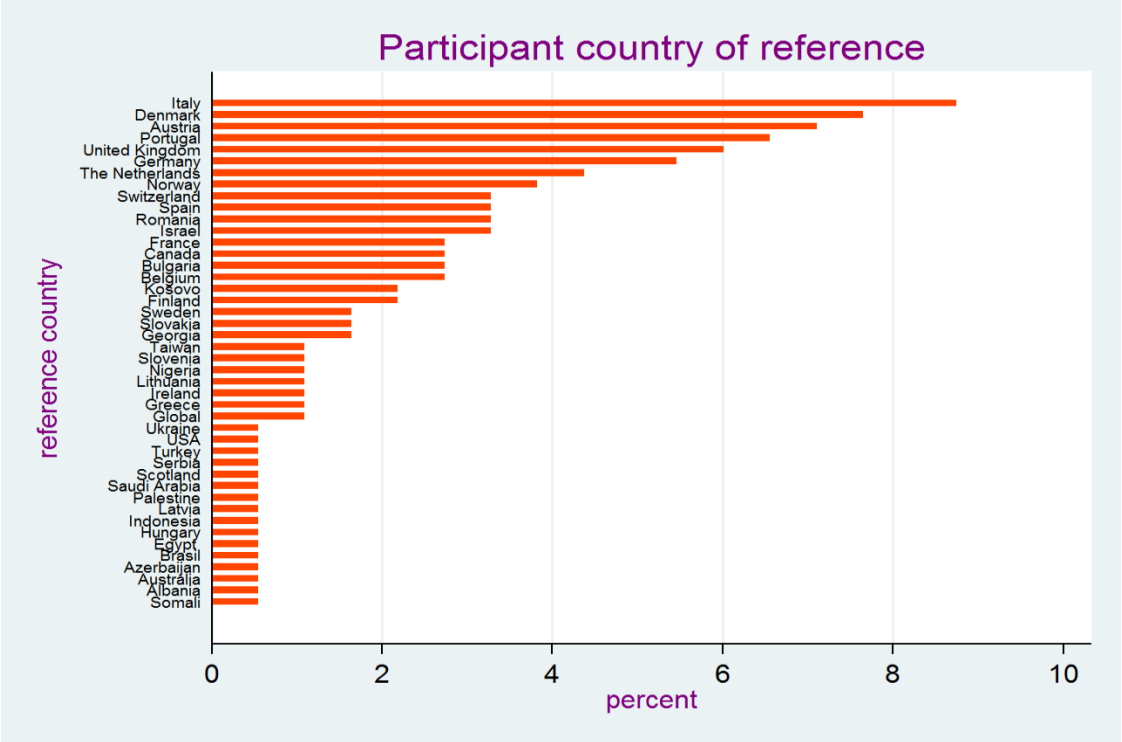

Figure 6: Participant country of reference

	F	%
Age:		
<25 years	3	1.55%
25-34 years	35	18.13%
35-44 years	38	19.69%
45-54 years	56	29.02%
55-64 years	46	23.83%
>65 years	15	7.77%
Total	193	100.00%
Gender:		
Female	128	67.02%
Male	63	32.98%
Global Region:		
Southern European	54	29.51%
Western European	47	25.68%
Northern European	45	24.59%
Eastern European	19	10.38%
Other	18	9.84%
Total	183	100.00%

Figure 7: Table of Socio-demographics

4.5 VARIABLES

Elements of Health Promotion's relevance were explored through the presentation of various questions and statements in the survey. Participants were asked to reflect on their perceived progress of Health Promotion since the Ottawa Charter's development 30 years ago and to state the level to which they agreed or disagreed with various statements. Content of statements included whether or not the field of Health Promotion is well established in their own country of reference, in Europe, whether or not the topic of Health Promotion has progressed, and if health promotion is in need of a greater reflection. 5 category options were provided to identify with the statements: Strongly agree, Agree, Unsure, Disagree, and Strongly disagree. For the analysis, Strongly Agree and Agree were collapsed into one category, Unsure was independent, while Strongly disagree and Disagree were collapsed into another category resulting in a total of 3 categories.

Perceived use of Ottawa Charter Action Areas was evaluated with a different series of options. Respondents were asked to reflect on the 5 action areas of the Ottawa Charter (Developing healthy public policy, Creating supportive environments, Strengthening community action, Developing personal skills and knowledge, Re-orientation of health services) and rank their use and application in Health Promotion practices in their reference country from "Never used" to "Used very Often". For each action area, a rank of 5 options was presented to respondents in order to categorize perceived use: I do not know, Never used, Sometimes used, Used regularly, and Used very often. Further analysis collapsed Used regularly and Used very often into one category, and evaluated frequency of perceived use in valid percent according to respondent's global region and professional domain.

Participants were given the option to answer yes or no to questions such as the whether the topic of Health Promotion is one of interest and engagement within the health field, known and valued outside of the health field, and whether or not respondents identified it as a necessary field. Open questions asked participants to explain reasons for responding yes or no, to provide a personal definition for health promotion, and identify any strengths and opportunities or weaknesses and threats associated with the field. Furthermore, respondents were invited to share perceived challenges of working in the Health Promotion field.

Final questions invited additional details of activities related to health promotion, whether respondents were members of EUPHA and the Health Promotion Section, as well as space to provide additional comments for the EUPHA Health Promotion Section.

4.6 DATA ANALYSIS

Data from the questionnaires were entered STATA 14.0 and descriptive statistics were conducted in STATA 14.0. A chi square test was conducted to determine the measures of association between certain variables such as WHO Region and Professional Domain with perceived applicability of each of the 5 actions areas. Open questions were organized and analyzed in Microsoft Excel 2010. Interpretation of text from participant responses to open-ended questions in the survey was guided by the processes of qualitative inquiry and data analysis by John Creswell (2013). Creswell advises that qualitative approaches are to be used when greater exploration of an issue is required, to better understand the experiences of a specific population and capture their voices and stories, to detect variables which may be challenging to measure, and to supplement quantitative data, providing an extension of the data or revealing potential associations or relationships (Creswell, 2013). Furthermore, "reporting multiple perspectives" and "identifying many factors involved in a situation" while painting a greater, evolving picture is what allows qualitative inquiry to be a holistic approach (Creswell, 2013) and thus appropriate for this study. Though focused on data derived in small groups and interviews as opposed to surveys, Creswell advises open coding of raw data and organizing material into meaningful units, categories and themes in an emerging process (Creswell 2013). In this study, various open questions were offered for participants to elaborate on their answers. Phrases from open questions were coded based on their content into meaningful units, then assigned names into categories, and further into five broader and central themes to make sense of and link the data (Creswell, 2013). This allowed for the building of in depth descriptions that interpreted both the opinions of survey participants as well as various views in the literature (Creswell, 2013). Frequencies of keywords and phrases derived from the content were recorded and reported according to participant profession and region. Regarding reflexivity, the background of the writer as a health professional and public health student should be considered as this may inadvertently influence the interpretation of the data and its classification.

5. **RESULTS**

5.1 WHAT IS HEALTH PROMOTION

In order to explore what the Ottawa Charter and Health Promotion represents, participants were asked to respond to the open-ended question "What is health promotion to you? 131 respondents replied with their personal definitions of the Ottawa Charter. The highest number of participants associated HP with Individual and community empowerment (19) and WHO/Ottawa's definition, (18) while fewer felt that the OC reflected Shared responsibiliy for health (4) or that it was Difficult to define (3). Other definitions included: Supporting and creating healthy lifestyles (15), Health education, knowledge and skills (15), Supportive environments (12), Health maintenance and improvement (12), Overcoming health threats, barriers and root causes(10), Improving structures, systems and determinants (10), Positive health, wellbeing and quality of

life (8) and Prevention of diseases (6). Participants elaborated and shared various other definitions further categorized into categories as observed in Figure 8.

Individual and community empowerment (19)

Empowerment was a term that was frequently used in connection to HP's definition and considered essential for the attainment of health. As one prevention care worker and public health practitioner from Greece stated, HP was connected with "empowering individuals, communities and social systems to achieve overall health (physical, mental, psychological) and health equity." Another participant (researcher from Denmark) reflected that Health Promotion means "to strengthen health in a population by empowering people, communities, and societies."

Empowerment implied taking responsibility for health on various different levels. A health promoter from Israel shared that "health promotion is a topic that can be used to develop a community orientation action to lead a person or people to take responsibity for his/ their health, by using several strategies to perform it." Furthermore, the protection of people's lives and environments was connected to the process of such empowerment within Health Promotion. "It's a real empowerment of people and communities in order to protect and promote their lives in the setting they live in," reflects a health promoter in Italy. A health promoter and researcher in Spain defines HP as "the process to enable communities and citizens (everybody) to control their health, mainly by having the resources and capabilities to influence policies, to control governments –at any level- and corporations in order to assure healthy and sustainable policies that tackle commercial, social and environmental determinants of health as well as social inequalities

WHO/Ottawa Charter definition (18)

According to 18 survey participants, the WHO/Ottawa Charter definition of Health Promotion was favourable to them. A public health practitioner in the UK shares, "I like the WHO definition - process of enabling people to increase control over and improve health, with focus on influence of social and physical environment**."** An educator in Germany states, "I can live well with the Ottawa-Charter definition," while a health promoter and researcher in Spain believes that health promotion is defined by "the Otawa definition and the 5 key points on action including equity and advocacy."

An educator in Slovakia discusses how in theory, the Ottawa Charter definition works but is defined differently in reality. "Health Promotion in theory I understand as it is defined by Ottawa charter - very idealistic. I can imagine to realize health promotion initiatives at local level as community based activities feeds by cooperation among professionals, decision makers and representatives of academia. In reality I can define health promotion as it is: health education intervention done by regional public health institutes + some media campaigns on health."

Supporting and creating healthy lifestyles (15)

Another definition of HP identified among 15 participant responses was the notion that HP's definition is closely linked with the action of supporting and creating healthy lifestyles. As a public health practitioner in Israel noted,"working with the population to improve their overall health, in all its aspects" was considered to be the crux of Health Promotion. Other respondents provided more specific explanations. One researcher from Portugal considerd HP to be a "group of stategies, initiatives, programs and interventions that aim to promote health of the population and mitigate the social determinants of health." A researcher in the Netherlands defined HP as "all activities/policies/interventions/environmental changes that stimulate healthy living." Promoting or improving health is also seen as requiring the cooperation and support of diverse resources for diverse populations. "Efforts to improve health through different measures and ways, involving different people, institutions. It applies to all people, healthy and sick,"states an educator in Lithuania. Another respondent (public health practitioner in Netherlands) mentions that Health Promotion involves influencing life and behaviour patterns by defining it as "all activities that increase chances for a healthy life through behaviour /lifestyle." Resources and risks were also considered essential with one researcher and educator in Austria considering that HP means "to enhance resources of health and to minimize risks, which can affect health status".

Health education, knowledge and skills (15)

The same number of respondents (15) indicated HP's connection to health education, knowledge, and skills. For these respondents, skills and knowledge were considered to be essential to the promotion of health. As one respondent (researcher in Romania) stated, "Health Promotion is about helping people to attain skills and knowledge in order to improve their health." The provision of such skills and knowledge were thought to be vital to making intentional choices conducive to health. As a UK researcher explains, HP is about "providing people with the tools required to help enable them to make informed choices about their health and wellbeing." Health education programs were also considered to positively impact behaviours and environments as suggested by another participant (health promoter and researcher in Azerbaijan) who felt that health promotion is "the strategy aimed at improving the health and well-being through the health education programs on different topics and designed to support changes in behavior and in the environment." Another respondent points out that knowledge and skills not only improve individual behaviours, but can be used to assist others and stimulate community impact. As a prevention care worker in Scotland reflects, "Health Promotion is the art and science of providing communities with the knowledge and skills to improve their own health and to take responsibility for the health of others, thus producing resilient communities. A UK researcher and educator further defined HP as "the process of enabling people to transfer knowledge into practice."

Supportive environments (12)

12 participants perceived that supportive environments was a vital concept in defining Health Promotion. According to these individuals, creating and providing the right environments and components within those environments were essential to a population's health, wellbeing, and quality of life. As one participant (researcher and educator Palestine) states, Health Promotion is "the process of creating an environment that encourages population groups to adopt healthier choices. The environment may include the physical environment, available resources, and education." Another mentions various dimensions of environments that can impact families as well as individuals. "Health Promotion is the provision of supportive environments- physical, social and policy- to best support people in improving their quality of life, both for themselves and their families, "shares a public health practitioner in United Kingdom. The importance of health messages in school activities as well as in the media were also strongly emphasized. "Health promotion should be included in every educational activity, starting from elementary school and on, with the strong support from media," reflects an educator in Kosovo.

Convenience towards making healthy choices was also considerered crucial to resilience in staying healthy with or without the presence of health challenges. "Making the healthiest choices the easiest choices"was identified as a role of Health Promotion as well as "to create the proper environment of choice for citizens in order to stay healthy and/or improve their abilities to cope with health problems." Another participant (researcher and educator in Germany) notes how supportive environments can also be manifested by "healthier working conditions, easier access to health services for poor people, better knowledge of selfcare."

Health maintenance and improvement (12)

Health maintenance and improvement was a a category among 12 participants when relating to the definition of Health Promotion. Health Promotion was considered as a process that not only improves health, but also as an "active approach to ensuring the health of the healthy".

In practice, Health Promotion is seen to consist of complex and systematic activities to improve or regulate health performance and change peoples lives. One example given includes focusing on "individual behaviours through environmental or social interventions." As another respondent (researcher, Denmark) reiterates, it is complex by potentially impacting various personal dimensions. They state that "health promotion is a concept covering self-monitored or assisted improvements of a person's or a group's health performance, be it physical, psychological, social or existential." The improvement of health was also associated with "being in more control of their health and its determinants" and "preventing future health problems." A health promoter in France emphasizes such determinants as allowing health to be created, as well as maintained and improved, within global shifts. "Health Promotion is the study of, the movement for

and the actions behind the resources and circumstances that allow people and communities to create, maintain or improve health in a changing world."

Overcoming health threats, barriers and root causes (10)

10 respondents felt that overcoming health threats, barriers and root causes were crucial aspects to the definition of Health Promotion. Overcoming such challenges was often associated with the word "fight" with statements such as "Health Promotion is a unique tool to fight against social health inequalities" or to "fight against topics promoted by food and health industries." Another respondent suggested that fighting against health barriers is necessary for optimal outcomes and conditions. A health promoter and researcher in Denmark expressed that HP meant "ensuring the best health outcomes for all members of society by creating the best conditions for health for populations. This means tackling problems within society that get in the way of health, as well as promoting existing best practice." Another respondent (researcher in the UK) clarifies that "research, practice, and other activity (including advocating and lobbying) for/ about interventions and conditions that promote good health for everybody. We understand that the most effective health promotion interventions address the social ("upstream") determinants of health, but we also work with individuals to help them overcome their own personal barriers to good health."

Furthermore, barriers are seen as consequences of unaddressed factors that need to be brought to the surface to improve access to elements cultivating health and wellbeing. "Health Promotion means addressing social, political, cultural, environmental, and structural factors as well as factors resulting from personal history and capacity that present barriers to accessing the resources and assistance available and necessary to achieve and remain in the best state of personal health and wellbeing possible,"states a health promoter in Germany. Though individual behaviours were noted to be crucial towards positive or negative health outcomes, the interventions and conditions initiated by political involvment were commonly seen as something which influenced "individual and community practices to affect good health." Finally, identifying and targeting root causes of problems were considered vital to create positive change, as well as change initited by the individual themselves. As one participant explains, "it is looking at what the underlying reasons for a state of "dis"ease are, and then targeting those root causes. It should address a "dis"ease from multiple angles in order to increase its effectiveness. The path of change should be created by those affected."

Improving health systems and determinants (10)

Improving systems and determinants was a common category arising in defining Health Promotion among 10 individuals. One respondent (researcher in UK) considers this by stating "Personally, I consider Health Promotion to have merged with the new language of population health, which tries to emphasize the structural and systemic contributors to health." As another respondent working in Italy and South America explains, these structural determinants appear outside the health system and Health Promotion deals with

determinants of health, that are mainly found outside the health system but greatly impact it. The researcher and public health practitioner communicates that "Health Promotion deals with determinants of health, that are mainly found outside the health system. In our globalised era, where politics obey neoliberal economic laws, it is important to focus on structural determinants of health (in addition to the intermediate ones)and act on trade, fiscal and redistribution policies: we can not talk about health promotion if the richest 1% of the world owns more wealth than the rest of the world combined."

Structural changes and a salutogenic approach were also seen to be of great importance. "I do not have a clear definition: But it involves a salutogenic approach and addressing social determinants of health, thus emphasizing a structural rather than an individual approach" voiced a researcher from Denmark.

Changes were also seen as something requiring political activity and the need to make healthy choices more accessible. As one researcher in Germany articulates, "Health Promotion is the "health in all policies" process on all levels to enabling individuals and communities to make the healthier choice the easy choice." A UK researcher suggests that Health Promotion includes "publicly funded initiatives to encourage healthy lifestyles, policies that discourage actual or potential harm to others (within reason), keeping public awareness (of health issues) high, facing up to corporates." A health promoter and researcher in the Netherlands emphasizes the provision and consistency of healthy approaches and choices across the lifespan and shares that Health Promotion is "a systematic and comprehensive approach across the lifespan to improve knowledge, attitudes and behavior that leads to avoiding health risks and that supports communities and societies to make the healthy choice the easy choice."

Improving systems and determinants was perceived as requiring certain conditions and structures conducive to health, and some perceived the component of partnership, versus a paternalistic approach, as being vital to a successful process within Health Promotion. "Health Promotion is providing conditions, environment, structures, empowerment and skills for people to enhance health in communities and individually. It is doing this in partnership and WITH people instead of FOR people,"states a researcher and educator in Denmark.

Positive health, wellbeing and quality of life (8)

Positive health, wellbeing and quality of life(8) was another emerging theme within the definition of Health Promotion. The perspective regarding Health Promotion leans in on positive aspects, personal potential, autonomy, empowerment, quality of life, as well as "enabling a healthy lifestyle"and "achieving better well-being" for individuals and communities. A prevention care worker and health promoter in Belgium reflects:

> Health Promotion is a new perspective on health. It considers the positive aspects of health including well being and sees the individuals and the communities through in an holistic way and through their positive potentials rather than "health prevention" that sees individuals though their negative

> potentials. Health promotion seeks to acknowledge these positive potentials (like the potential to feel happy, to enjoy life, to make activities and have a lifestyle that are fulfilling...) and to empower them by giving people autonomy in their choices, providing counseling (with equity and not in a paternalistic manner) and resources to attain the goals people feel are needed. Its take a bottom up approach to start from people needs and reality and provide the resources and structure needed to empower individuals and community attaining their goals.

Another respondent (health promoter and educator in Switzerland) discusses such positive health as well as the word "promotion" in its definition and the importance of equity in the process of Health Promotion.

> To understand Health Promotion it is important to understand health. Health is a combination of high life-quality (notably external factors) and well-being (notably personal factors). Health has physical, psycological, social, socio-cultural and spiritual aspects. "Promotion" means: Enhance these different factors or aspects of well-being and life-quality. An important topic in this process is equity: Especially social health grows only, if the results of health promotion indicate a better equity: a lower inequality in the expectations of a good health.

Prevention of diseases (6)

Perceiving Health Promotion as the prevention of diseases was a common category in the responses of 6 individuals. To one respondent (researcher and research funder in Ireland), Health Promotion is viewed as "promoting wellbeing and health through preventative measures, while a public health practitioner in Saudi Arabia shares, "In my view, it relates with promoting health in a preventive and curative manner." Such measures were described by another respondent as "all the policies, programs, activities, resources and people involved in preventing disease and in supporting a healthy and fruitful lifestyle, in a healthy physical and social environment." Another participant stated that in order to prevent diseases, emphasis is required to "ensure the knowledge of the population starting with early age." Various other measures were also described as necessary to improve prevention efforts, particularly in countries where they were perceived as lacking. "In Romania we need more Health Promotion programes, more practical community interventions, more feed-back evaluation from medical staff, population and stakeholders as well, and more data disemination and accesibility to it."

Healthy perspectives of populations was also seen as one way prevention could be manifested. This was described by one participant as a "state of mind to care about the future every minute and to be responsible." A curative/palliative care worker from Portugal also shares, "Health Promotion means assuming healthy behaviour lifestyles to avoid the emergency of any disease. If people have any health risk factor, this is more a personal responsibility rather than the healthcare system. Health Promotion should work best if closely linked to the concept of primordial and primary prevention."

Shared responsibility for health (4)

Shared responsibility for health was also indicated as a category among 4 participants who indicated that health should be in all areas and requires a unified effort and attitude. "Basically, Health Promotion is advocating health, in all areas, and its concrete understanding as it relates to every individual person so that it is comprehended and implemented on a daily basis," states a health promoter and researcher in Austria. HP was also identified as "the common effort to promote health for individuals and populations" by a curative and palliative care worker in Austria.

An international approach that encompasses and connects broad disciplines was also emphasized. "It is a global approach of health not only focused on healthcare and prevention, but on environments, life skills, giving a central place to the users. It legitimizes diverse actors working outside the public health field: educators, managers, decision makers, urbanists, architects for and with the community," shares a public health practitioner in France. These actors should be motivated to create positive scenarios for optimal wellbeing for people and society. "Health Promotion is a complex process in which multiple sectors and professionals should be involved, starting from a shared positive concept of health and continuing by a common training and planning in the governance of public good."

Difficult to define (2)

Two individuals stated that Health Promotion is too difficult to define.

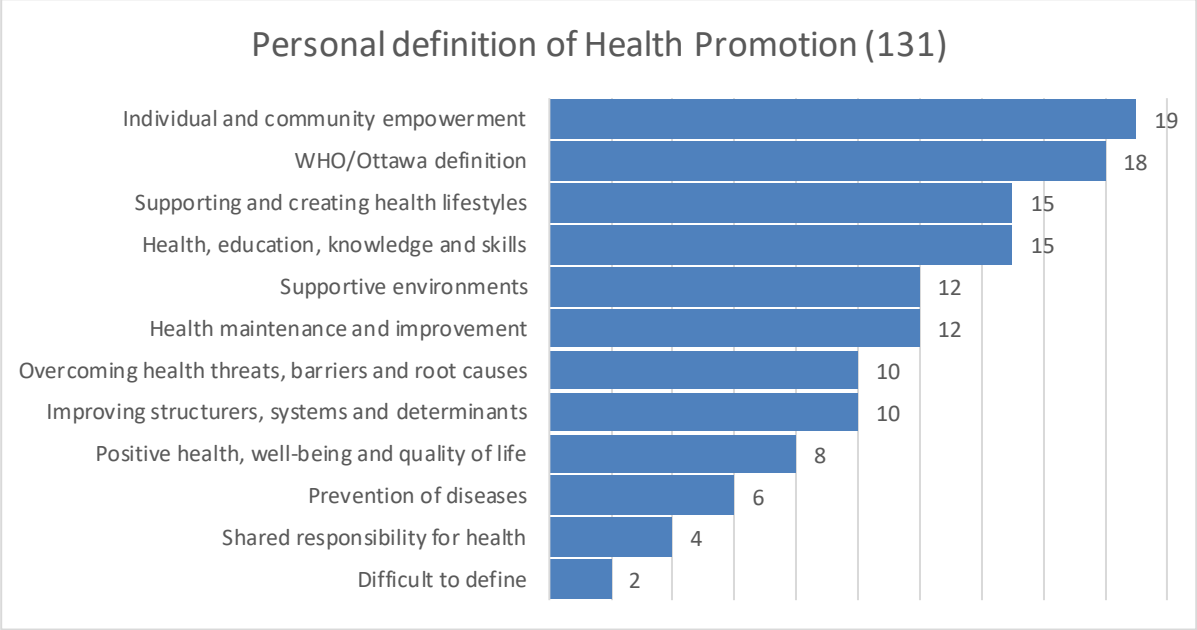

Figure 8: Personal Definition of Health Promotion

5.2 PERCEIVED PROGRESS OF HEALTH PROMOTION

Due to the acknowledgment of various changes which have occurred since the Ottawa Charter's development, participants were asked various questions addressing the perceived progress within the field of Health Promotion since the Charter. Four questions focused on HP progress and five ranking options were offered for each question. Participants who answered either Strongly agree or agree were collapsed into one category, while Strongly disagree and disagree were collapsed into another and Unsure was an independent category. 43.7% of respondents agreed that the field of Health Promotion is well established in their country, with 30% disagreeing and 26.3% being unsure. When asked whether they felt that Health Promotion was well established in Europe, 50% agreed, 17.9% disagreed, and 32.1% were unsure. Although 80% of survey participants felt that the topic of Health Promotion has progressed over the past 30 years (with 9.5% disagreeing and 10.5% unsure), 80.7% (with 5.7% disagreeing and 10.5% unsure) felt that the topic of Health Promotion needs a deeper reflection since the development of the Ottawa Charter.

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

Figure 9: Perceived progress of Health Promotion

5.3 PERCEIVED USE OF OTTAWA CHARTER ACTION AREAS

5.3 a FREQUENCY OF USE OF THE ACTION AREAS

In order to assess how the Charter and Health Promotion concepts have been applied to date, participants were asked to rate their perceived use of the five Ottawa Charter action areas in their reference country. After collapsing the categories of Used regularly/Used very often into one category, the percentage of use of the five action areas in one´s country was rated highest for "Developing personal skills and knowledge" at 63.7%, followed by "Developing healthy public policy" at 44.3%, with the rate slightly dropping for Strengthening community action at 41.1%, declining to 36.3% for Creating supportive environments, and lowest for "Reorientation of health services" with a 30.5% response rate. Action areas which were perceived as Never used in the reference country of respondents was highest for Reorientation of health services at 10%, followed by Developing healthy public policy at 7.3%, Strengthening community action at 4.7%, Creating supportive environments at 2.6%, and Developing personal skills and knowledge at 1.6%.

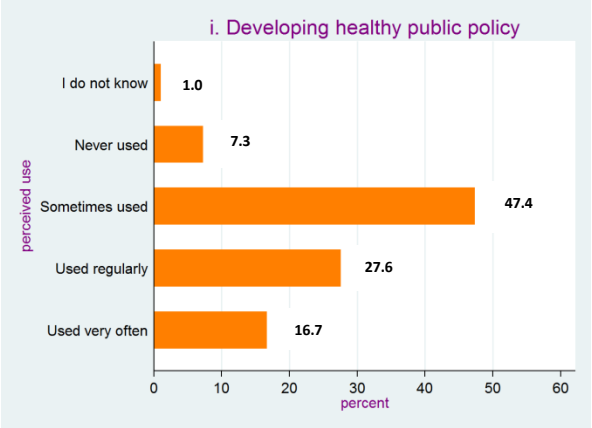

Figure 10: Perceived use of 'Developing healthy public policy' in reference country

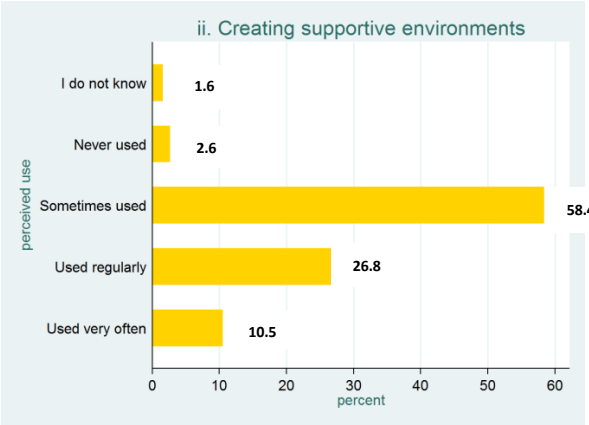

Figure 11: Perceived use of 'Creating supportive environments' in reference country

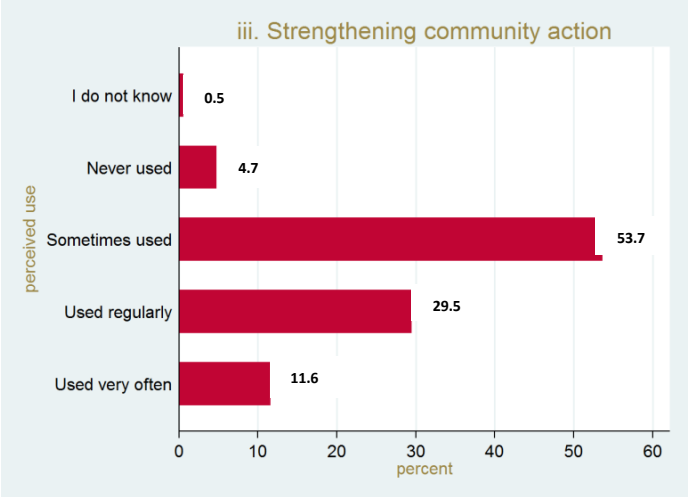

Figure 12: Perceived use of 'Strengthening community action' in reference country- Ottawa Charter and Health Promotion Cross Sectional Survey 2016

Figure 13: Perceived use of 'Developing personal skills and knowledge' in reference country

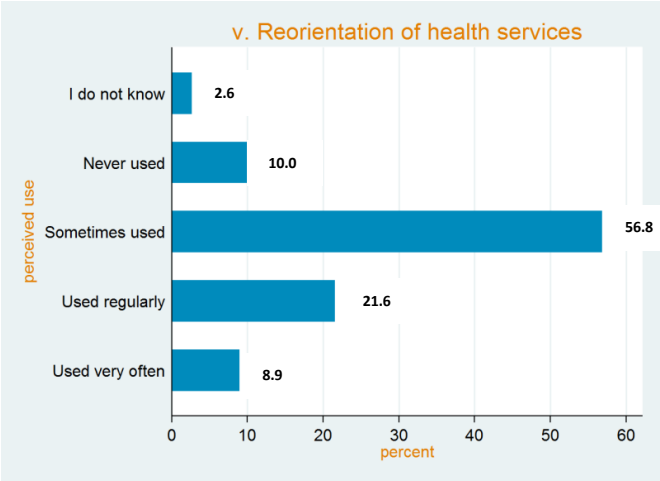

Figure 14: Perceived use of 'Reorientation of health services' in reference country

5.3 b FREQUENCY OF USE IN THE GLOBAL REGIONS

Data was further analyzed to explore perceived use of action areas according to global region. Southern Europe (54 respondents), Western Europe (47), Northern Europe (45), Eastern Europe (19) and Other (17) were global regions that ranked use of action areas with a total of 182 respondents. Among Europeans, Healthy public policy use was rated highest among Northern Europeans (53.3%), followed by Southern European at 44.4%, Eastern European at 42.1% and Western European at 36.2% with no significant difference between regions (Chi square test P value of 0.559). Supportive environments was rated highest among Northern Europeans (48.9%), followed by Western Europeans at 38.3%, Southern Europeans at 28.3% and Eastern Europeans at 10.5%, with no significant difference between regions (Chi square test P value of 0.008). Strengthening community action was highest among Northern Europeans at 53.3%, Western Europeans at 42.6%, Southern Europeans at 31.5% and Eastern Europeans at 10.5%, with a significant difference between regions (Chi square test P value at 0.003). Developing personal skills was

highest among Western Europeans at 74.5%, Northern Europeans at 71.1%, and Eastern Europeans at 52.6% with no significant difference between regions (Chi square test P value 0.068). Reorientation of health services was highest among Northern Europeans at 35.6%, Western Europeans at 34%, Southern Europeans at 25.9% and Eastern Europeans at 21.1%, with no significant difference between regions (Chi square test P value of 0.677). All calculations are in valid percent.

Global Region	Healthy public policy		Supportive environments		Strengthening community action		Developing personal skills		Reorientation of health services	
	N	%	N	%	N	%	N	%	N	%
Southern European N= 54	24	**44.4**	15	**28.3**	17	**31.5**	27	**50.0**	14	**25.9**
Western European N= 47	17	**36.2**	18	**38.3**	20	**42.6**	35	**74.5**	16	**34.0**
Northern European N=45	24	**53.3**	22	**48.9**	24	**53.3**	32	**71.1**	16	**35.6**
Eastern European N= 19	8	**42.1**	2	**10.5**	2	**10.5**	10	**52.6**	4	**21.1**
Other N=17	9	**50.0**	10	**58.8**	11	**64.7**	11	**64.7**	6	**35.3**
Total N=182	82	**44.8**	67	**37.0**	74	**40.7**	115	**63.2**	56	**30.3**
Chi square test P Value	0.559		0.008		0.003		0.068		0.677	

Figure 15: Frequency of perceived use of Ottawa Charter action areas (in valid percent) according to Global Region

5.3 c FREQUENCY OF USE BY PROFESSIONAL DOMAIN

Frequencies were also observed according to the professional domain of respondents. Categories of curative/palliative/prevention worker included 19 respondents, 70 were in the category of Health promotion/public health practitioner/public health administration, and 101 represented Researcher and/or Teaching/Education with a total of 190 respondents. Healthy public policy was perceived to be used by 52.6% of Curative/palliative/prevention workers, 36.6% of health promotion and public health practitioners and administrators, and 48% of researchers and educators with no significant difference between domains. Supportive environments was perceived as used by 41.6% of researchers and educators, 32.9% of health promotion and public health practitioners and 31.6% of curative/palliative/prevention workers, with no significant difference between domains (Chi square test P value of 0.439). Strengthening community action was perceived as used by 47.4% of curative/palliative/prevention workers, 41.6% of researchers and educators, and 38.6% of Health Promotion and public health practitioners and administrators, with no significant difference between domains (Chi square test P value of 0.778). Developing personal skills was said to be used by 66.3% of researchers and educators, 64.3% of health promotion and public health

practitioners and administrators, and 47.4% of curative/palliative and prevention workers, with no significant difference between domains (Chi square test P value of 0.286). Reorientation of health services was declared as used by 32.7% of researchers and educators, 30% of health promotion and public health practitioners and administrators, and 21.1% of curative/palliative prevention workers, with no significant difference between domains.

Professional domain	Healthy public policy		Supportive environments		Strengthening community action		Developing personal skills		Reorientation of health services	
	N	%	N	%	N	%	N	%	N	%
Curative/palliative/prevention worker N= 19	10	**52.6**	6	**31.6**	9	**47.4**	9	**47.4**	4	**21.1**
Health promotion/public health practitioner/public health administration N=70	26	**36.6**	23	**32.9**	27	**38.6**	45	**64.3**	21	**30.0**
Researcher and/or Teaching/Education N= 101	49	**48.0**	42	**41.6**	42	**41.6**	67	**66.3**	33	**32.7**
Total N=190	85	**44.3**	71	**37.4**	78	**41.1**	121	**63.7**	58	**30.5**
Chi square test P Value	0.245		0.439		0.778		0.286		0.597	

Figure 16: Frequency of perceived use of Ottawa Charter action areas (in valid percent) according to Professional domain

5.4 PERCEIVED VALUE OF HEALTH PROMOTION

The perceived value of Health Promotion is reflected by three yes or no questions as displayed in *Figure 17*, contributing to exploring the question of whether the Charter is known and recognized in today's context. Questions 1 and 2 provided an option for participants to elaborate on their reasons for stating yes or no, while Question 3 remains a yes or no question. Open responses from questions 1 and 2 were analyzed according to qualitative inquiry. Phrases and keywords were organized into meaningful units based on the content of their comments, developed into categories, (Creswell, 2013) and frequencies were recorded and reported according to participant profession and region.

Questions:	Yes %	No %
1: Is health promotion a topic that stimulates interest and engagement for health professionals, researchers and policymakers?	72.1%	27.9%
2: Is health promotion a topic that is known, understood and valued outside of the Public Health Field?	40%	60%
3: Do you feel that health promotion is a necessary field?	72.5%	27.5%

Figure 17: Perceived value and recognition of Health Promotion

In response to Question 1, 72.1% of respondents agreed that Health Promotion is a topic that stimulates interest and engagement for health professionals, researchers and policy makers (see *Figure 17 in 5.4a*). *Figure 18* reflects how 40 of 112 respondents who elaborated on their reasoning for this question gave

several reasons to support such interest within the public health field which included: Increasing health interest and concern (14) Holistic and positive vision (10), Complementary to other roles, fields and sectors (7), Multi-level impact (5), and Progress of HP presence and importance (4). *Figure 19* reflects how 72 of 112 respondents who elaborated on this question gave various reasons explaining why they perceived a lack of interest within the public health field which included: Intention but lack of action (16), Curative/disease oriented perspectives (11), Unclear concept (10), Conflict of interest and lack of intersectionality (10), Lack of political will and investment (8), Lack of immediate outcomes and evidence (7) Lack of awareness and appreciation (6), Professional Progress required (4). Participant perspectives are further described in section 4.3a.

Regarding question 2, about 40% of respondents agreed that health promotion is a topic that is known, understood and valued outside of the Public Health field, among the public. (see *Figure 17*). *Figure 20* reflects how 32 of 111 respondents gave several reasons to support such interest which included: Health conscious citizens and stakeholders (11), Effective intersectoral collaboration (10), Increasing awareness and impact (8), and Setting and field dependent (3). 60% of respondents for this question believed that Health Promotion is not well known and valued among the public (*Figure 21*) and 79 of 111 of those participants provided their opinion regarding factors influencing this: Unclear concept (20), Low awareness (14), Curative/disease oriented perspectives (12), Lack of political will and intersectionality (10), Lack of immediate outcomes and evidence (8), Lack of value (7), Behaviour change (5) and Professional progress required (3). Perspectives of respondents are further described in section 4.3 b. According to question 3, 72.5% of respondents felt that HP is a necessary field, however no open comments were offered for participants to explain why or why not.

5.4 a HEALTH PROMOTION RECOGNITION AMONG HEALTH PROFESSIONALS, RESEARCHERS AND POLICY MAKERS

Factors positively associated with Health Promotion recognition in the field

72.1% of respondents agreed that Health Promotion is a topic that stimulates interest and engagement for health professionals, researchers and policy makers (see *Figure 17*). *Figure 18* reflects how 40 of 112 respondents gave several reasons to support such interest which included: Increasing health interest and concern (14) Holistic and positive vision (10), Complementary to other roles, fields and sectors (7), Multi-level impact (5), and Progress of HP presence and importance (4).

Increasing health interest and concern (14)

Some respondents reported that there is a perceived increase of health interest and concern observable through “active academic interest” as well as policy and that health promotion has become “a very hot topic.” “We can see an increasing number of Health Promotion studies being established at German

Universities, particularly Universities of Applied Science," states a researcher and educator in Germany. There is also mention of "an active professional interest in government and public health service" while a researcher and research funder in Ireland stated that "recent policy for health services has highlighted the need for health promotion across all sectors." Norway has been specifically mentioned as recently having integrated health promotion into policy documents, while an educator from the UK also points to a shift in perspective by stating that "there has been a generational change in attitudes since the 1980s in UK. Nowadays all health professionals want to be seen to be health promoters!"

A health promoter and researcher in Italy noted that "all stakeholders are now interested in health" while yet a health promoter and public health practitioner in Italy states that "Health Promotion is very updated for people (nutrition, body activity, smoking, drinking etc.)." A health promoter and researcher in Denmark stated that "there is increasing awareness of the many advantages of health promotion for the individual and for society, that healthcare shouldn't just be reactive, but proactive."
Furthermore, such increasing concern is also attributed to the growing disease burden. A health promoter in the Netherlands shares:

> There is more interest in prevention in health care because of the increasing burden of chronic diseases and because of the new concept of positive health (the ability to adapt and to self-manage in the face physical, social and emotional challenges of life). This concept is popular and creates opportunities for Health Promotion.

While the concept of Health Promotion has been perceived as "stimulating" and "appealing," it is also mentioned that "its meaning is seldom correctly understood, that is, as defined and explained by the Ottawa Charter."

Holistic and positive vision (10)

Respondents emphasized the importance of the scope of the Charter which "works as a vision and orientation" and has a "positive societal impact on public discussions about appropriate ways to promote healthy living." Health Promotion is also described by respondents as "holistic," "relevant," and a "multi-disciplinary and interagency approach." Not only is this perceived to be reflected in the "combination of education and health supports for actions and conditions of living conducive to health" but also in the idea that "health promotion draws on a number of disciplines, including public health, political science, education, communication, anthropology, epidemiology, sociology and psychology, etc."

A health promoter and researcher in Austria further expressed:

> Health promotion puts healthy living in the center, which is in a broader sense the question "in which society we want to live?" This broad perspective allows decision makers to focus on long term perspectives and on a positive view of how societies can develop.

Furthermore, HP was described as surpassing the focus on individual behavior, yet having both a social and individual impact, as well as financial and environmental. "Health Promotion includes social, environmental and political processes that encourage individuals, groups of people and populations to increase control over, and to improve their health," states one respondent. The scope of HP is also perceived, by some respondents, to be an inclusive and collective "strategy to improve the quality of life and wellbeing of people."

Complementary to other roles, fields and sectors (7)

Several respondents shared their reason for HP stimulating interest and engagement which included that Health Promotion is complementary to other roles, fields and sectors. As one respondent notes, it is stimulating "because it is (or may be) a field of action for all three categories." Another participant shares, "I believe, it is stimulating interest among those already in some sense occupied with the topic."
Such collaboration is seen also as convenient for stakeholders as it "complements their work." A curative/palliative care worker in Albania explains:

> Yes, it is a topic that stimulates interest and engagement because I think makes their work easier. Anyway, some interest must be shown from health workers, researchers, policymakers (in my country) in order to make it function properly so they can see how useful it is for their work and for the entire population.

Such collaboration is also viewed as a valuable contribution to Health Promotion vision and goals. A health promoter and researcher in Azerbaijan shares:

> They all (health professionals, researchers and policymakers) contribute for the perspective of Health Promotion. Actually, in control of risk factors which will prevent or delay the diseases (ex. stroke, coronary artery disease and cancer) and cost-effectiveness or cost/benefit effects of health promotion program.

It also was seen as contributing to the quality of professionals, health systems and citizens. As one public health practitioner in Somali reflects that "Health Promotion is what determines the performance and achievement of successful health professionals, researchers and policymakers. That is what stimulates and increases the quality of health care system and health civilization." Health promotion is also seen as complementary since it is viewed as encompassing elements of importance to realms other than health since "it is realized that health is a central theme for other domains as well."

Multi-level impact (5)

Health Promotion is also seen as a topic of interest and engagement because of its ability to create a diverse influence and "because of its impact on several levels." Health Promotion "covers all areas of interest" according to one respondent. A prevention care worker in Scotland elaborates:

> Health promotion relates to all those involved in the health field, whether they are working at the bedside or working in public health. It is a critical element of developing a sustainable health care system and helping reduce the strain on that system.

The multi-level impact is expressed as being beneficial for the health of individuals and communities, thus stimulating interest and engagement for those advocating for them. "It does (stimulate interest) because investment and action in health promotion has a significant impact on the determinants of health and reduce NCDs, so as to create the greatest health gain for individuals and communities," shares a researcher in France. Various gains to be experienced by actors on various levels are also acknowledged. "Health professionals in leading positions benefit from health promoting knowledge. Researchers gain more insights in working strategies. Policymakers do something for the clientele they are payed by," communicates a researcher and educator in Germany.

Progress of HP presence and importance (4)

Various observations related to Health Promotion have been identified which include the increasing presence of Health Promotion within educational and occupation settings, non-communicable disease burden, and national health policies. One educator in Norway mentions how "there are university programs in Health promotion and also positions within national, regional and local government." A health promoter in Portugal reflects about the move towards HP due to the shift in lifestyle and health trends:

> Recently, given the increased life expectancy and, with this, the increasing burden of non-communicable diseases, as well as recent threats to the sustainability of national health systems (among others) there's a greater focus on health promotion when, until very recently, the focus was almost exclusively on providing curative care.

One respondent discusses political movement towards Health Promotion as an indicator of its presence and importance. A health promoter and researcher in Switzerland explains that "national health policies are moving towards health promotion, policy recently started to promote primary care physicians to be active actors. the public/population does not yet understand this shift."

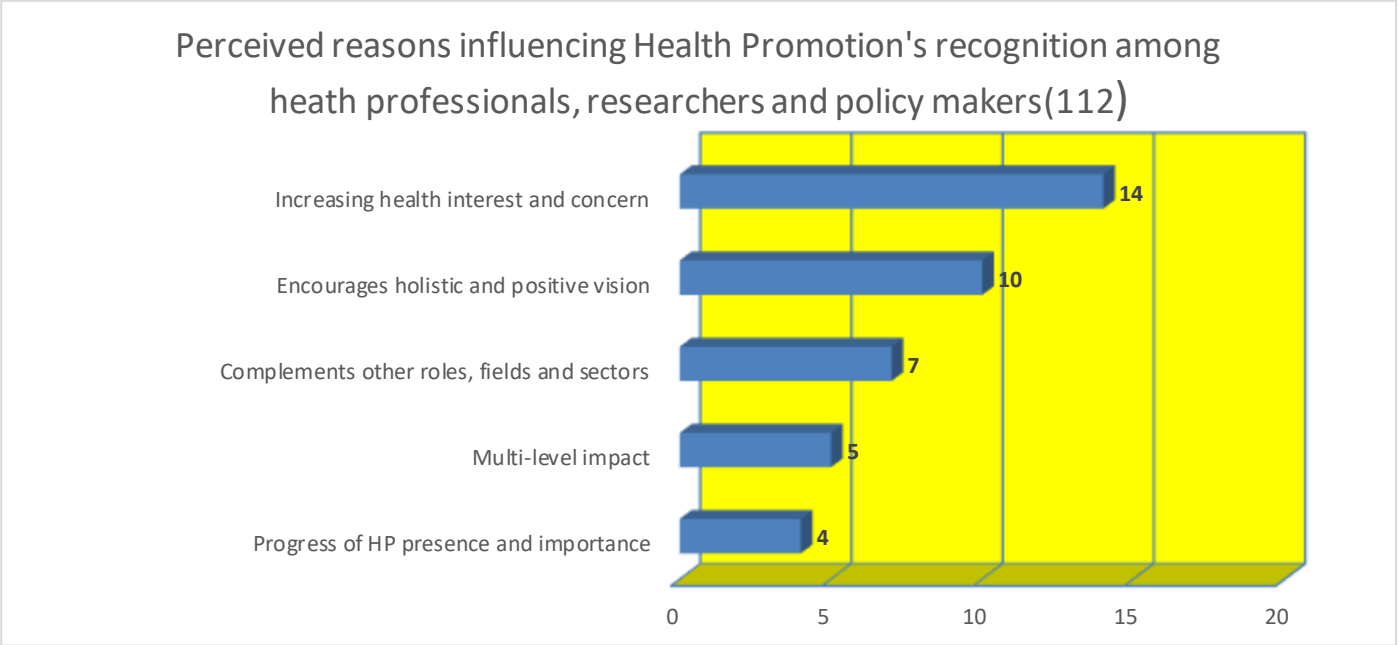

Figure 18: Perceived reasons influencing Health Promotion's recognition among health professionals, researchers and policy makers

Factors negatively associated with Health Promotion recognition in the field

27.9% of respondents who responded to this question did not feel that Health Promotion stimulates the interest and engagement of professionals contributing to the public health field (*See Figure 17)*. As observed in *Figure 19*, 72 of 112 respondents gave reasons such as: Intention but lack of action (16), Curative/disease oriented perspectives (11), Unclear concept (10), Conflict of interest and lack of intersectionality (10), Lack of political will and investment (8), Lack of immediate outcomes and evidence (7), Lack of awareness and appreciation (6), and Professional progress required (4).

Intention but lack of action (16)

16 respondents expressed the notion that though Health Promotion has great intentions, includes a "broad interest" and may be stimulating, these intentions are not always realized into a "concrete action plan" and is sometimes "superficial." Concepts and ideas of HP were seen as "largely lip service." One participant adds, "they talk the talk, but don't walk the walk." A Canadian researcher and public health practitioner states, **"**I think the idea of Health Promotion stimulates much interest and discussion but how it is actually applied, whether or not everyone is thinking the same way about what is effective, and what policies and practices are best to use are other issues entirely." A researcher and educator in Ireland mentions, "we have a lot of talk about health promotion and the language of health promotion is widely used. However, there is less meaningful application of the concepts, and impact evaluation is poor where it is undertaken."

The effort and work invested in health promotion isn't always viewed as put into practice. **"**Only words, meetings and documents. Not in practice. The very few initiatives that they call under "Health Promotion" are more health education programs," shares a researcher and health promoter in Italy.

Another participant shares that various actions in the period between one's contributions and end results of interventions or outcomes can make it seem like the work of "hard working, well intentioned and well-informed people in the field" is being ignored. During this period, there is "evidence being evaluated, policies being proposed...blurring of boundaries...misplaced good intent."

A curative/palliative care worker in Portugal discusses the struggle to integrate intentions and principles in line with Health Promotion in the healthcare sector. "There is a rising acknowledgment of health workers of the need to engage on prevention and promotion of healthy lifestyles but this has no a structured translation to the real time patient care; the promotion and preventive interventions have not yet been integrated on the daily routine of healthcare providers so, proactivity is still in the intention level." Overall, even though "conversations can be stimulating and uplifting," "achieve news coverage," or may be statutory in some countries, there are difficulties identified with achieving end results.

Curative/disease oriented (11)

A curative/disease oriented approach was identified as a reason impacting the perceived value of Health Promotion. Participants have indicated the focus on "therapy," "curative health," "medical treatment," "disease-oriented system," "hospitals" and "pharmaceuticals." With regards to their reference country, a prevention care worker and health promoter explains

> I think that the paradigm in Belgium is still directed towards prevention rather than promotion. So, Policymakers are rather stimulated by prevention or care. In the health sector, care givers become interested by health promotion but still have a vague idea about this concept.

Another respondent states, "In Egypt all interest goes to curative services rather than preventive services, especially health education and promotion." One respondent discusses the perspective that HP is seen as a specialty service, not seen as essential enough to be prioritized financially. By and large it is considered "extra" and "optional" compared to medicine and the organization of health care. "Public health administration is run by clinicians who have the wrong definition of health promotion and who don't see what purpose it serves. At the first sign of budgetary restriction, au revoir health promotion!" Another respondent explains how clinging to and solely relying on traditional forms of health care has various impacts for HP engagement:

> In many cases there is a sentiment attached to traditional reactive/treatment forms of 'heath care' which due to their funding have political impact (votes). As long as this remains the case then true reform of ailing existing health care systems that lack investment/interest in prevention will prevent any

> effective long-term behaviour change strategy. The over reliance on medical intervention, lack of hard hitting public education campaigns and the losing war on corporations in relation to their role in increasing NCDs..."

Strategies for NCDs were also seen as poor or nonexistent compared to communicable diseases,

Another respondent describes how the dominance of the biomedical perspective causes challenges for Health Promotion. "When it goes to health promotion a biomedical risk approach prevails and focuses on intermediate determinants of health and on personal responsibility, leaving aside the socio-economic and political context that creates and perpetrates inequalities."

A health promoter in Germany goes on to explain the situation in his country:

> It seems to still be an afterthought within health policy in general. While there are dedicated professionals, researchers and some policy makers working on the topic, they are far outweighed in number, policy focus and public and media attention by the traditional, curative responses of the health system. While the new Prevention Act in Germany places a stronger emphasis on prevention, there is still much resistance in the health sector.

Unclear concept (10)

10 participants commented that Health Promotion is not well understood and "still thought to be health education or disease prevention." A health promoter in Switzerland stated:

> Health professionals who are not directly involved in the field of health promotion have a lot difficulty to understand its role in the public health Sector. Policymakers also do not understand the meaning of health promotion, compared to the term of prevention.

Other respondents agree that "prevention" is used more frequently, if not synonymously. Another participant reflected that HP "is understood very differently across public health professionals." More specifically, "for officials from the ministry of health or public health physicians it equates with health education."

As a concept or topic, it is perceived as sometimes being unclear and challenging to understand. "I think the topic is difficult to understand and to grasp," states one participant. A health promoter and public health practitioner in Belgium explains:

> HP is often perceived as too loosely defined, too theoretical, with a broad spectrum of interests where the aim of health is lost. It also suffers from the difficulty to obtain collaboration from various agencies whose main preoccupations are not health. The multidisciplinary approach leads to a lack of visibility or in a contrary, a fear that HP actors get all the visibility from the work of other agencies.

Conflict of interest and lack of intersectionality (10)

A proportion of the respondents (10) indicated the perception that health promotion is competing against other "vital issues" and "there is a lack of intersectionality" and "no translation of knowledge." Due to big

problems that require prioritization, "some of the debate is over whether it (HP) is important or necessary." As an educator in Bulgaria states, "in our country health professionals have other kind of problems. Our health system is still under reform procedure and there are a lot of difficulties." There is a conflict of interest that is noticed among health professionals as well. "Unfortunately, there is a misfit of interests and lack of common understanding in the cooperation of all three domains (health professionals, researchers and policymakers using different definitions and aims)." Another respondent explains that "there is still much resistance in the health sector and not much public understanding in the population." In addition to resistance in the health sector, economic gains are seen as clashing with the goals of Health Promotion. This is best understood with the reflection of a researcher and educator in Italy:

> With health promotion, i.e. promoting healthy lives, breastfeeding, healthy eating, physical activity, you do not sell anything. In this time of deep economic crisis, any intervention that may interfere with industrial production is viewed with suspicion, and politically it is not supported. This is what is happening with breastfeeding protection, promotion & support, healthy eating in schools, sugar reduction, junk food advertising, tobacco and alcohol consumption. Nothing new, I guess, but there is too many non-official lobbying and conflict of interest.

Furthermore, different regions and countries have varying political views and systems which affects the way they view Health Promotion. One participant states:

> The issue I believe is the different political interpretations of what the focus of HP should be - those on the right wanting to focus on personal responsibility strategies and on the left wanting social policy change and environmental change as well as community capacity building as the focus. It often depends which political party is in power in which country as to which approach is in the ascendant.

Lack of political will and investment (8)

A few health professionals (8) shared that engagement is limited due to lack of political will and investment. As one health promoter and researcher in Romania states, HP "doesn't bring any money - not in the short run and not for the ones that have interest and decision-making power. So, health promotion is deeply under-financed and neglected." A curative/palliative care worker in Portugal shares that there is a shift towards prevention in politics, but it is still fragile:

> I think healthcare professional community is under current transition acknowledgement of the value of prevention for healthcare system. However, we are still at a very incipient process stage which can abort if decision makers' leadership don't have the needed strategic vision and due political will to effectively support the ongoing transition.

Others don't believe this recognition is as strong. "Health Promotion is not a topic of interest as a goal per se but more as means. HP is especially important to public health workers but not to the rest of the inhabitants

of policy makers," states a health promoter and researcher in the Netherlands. A researcher in the UK believes that whether HP is known and recognized depends on the political situation:

> It varies a lot with the political climate - our current conservative government has delegated public health to local authorities (as opposed to health bodies) and withdrawn much of the funding to maintain earlier initiatives. There has been an ideological shift to personal responsibility for health.

Another participant states that "the answer is not a clear yes or no answer in Austria. I believe that health promotion is being included to a greater extent in discussions, but I feel that the political engagement and the health professional engagement is lagging behind." The lack of political will is also seen as influencing resources and investment into Health Promotion and the question of capacity. A health promoter and researcher in Spain shares:

> Departments of health invest very little in health promotion. Nobody (other institutions in the community) ask for programs. The department has to "sell" health promotion. The big budget in public health are vaccines and far behind epidemiology and far behind health promotion. The budget and human resources have diminished greatly in the last years.

The lack of resources is then seeing as negatively impacting the decision of those in power "because there is not sufficient resources to motivate the decision makers in the level of the government and other ministries like Education and Health and Welfare ministries."

Lack of immediate outcomes and evidence (7)

One of the reasons HP is perceived as having difficulty stimulating interest and engagement is due to the process of Health Promotion where "the outcomes came after long period of time," and that "one does not get measurable results and recognition in the short term." In addition to lack of immediate outcomes, lack of evidence was also mentioned, and these factors are seen as contributing to the challenge of Health Promotion recognition. A health promoter and researcher in Finland states:

> The problem in health promotion is a weak efficiency in the many areas and also how to show the economic evidence of the health promotion. Quite often many professionals look at that the health promotion is only how to stop the smoking or the alcohol use or how to control the weight and so on. The point of the view is quite narrow. and the challenge is how to lift the health issues onto political level.

Lack of awareness and appreciation (6)

Even among health professionals, there is a perceived lack of awareness of Health Promotion principles and practice. One respondent even feels that "it is now less (recognized) than say 10 years ago." As an educator in Bulgaria states, "According to data from our study health professionals in the country are not well acquainted with the concept of health promotion." Another participant reflects that though health

professionals in training and practice like the idea of Health Promotion, "there is a deep lack of knowledge about the principles and methods about HP, between health workers." Another respondent agrees that it is "not a very known area. Even some researchers do not know what it is." One factor that is perceived to affect this awareness is that certain initiatives related to Health promotion may take place under a different name. "Most of the known initiatives are not enrolled with the topic of health promotion but they have impact on health promotion (e.g., the definition of Health of family Unit at local level, the construction of green parks)," shares a researcher from Portugal. Another participant believes that it Health Promotion has lost its popularity over the years. "HP lost its charm as a new and powerful strategy. Individualized thinking has become more and more common sense," explains a German health promoter and teacher.

Professional progress required (4)

4 participants discussed the need for professional progress within the Health Promotion field. On respondent argues that certain steps are necessary to increase professionalism, which is believed to enhance interest in HP. "Health Promotion needs to develop codes of conduct/standardized qualifications and explore ethical dilemmas and more regulation and a more professional standing in relation to other medical sectors to gain interest and increase effectiveness." Another believes that being better integrated into education and training would help enhance interest and engagement:

> If Health Promotion (HP) would be better integrated in the training/ post gradual training of health professionals, empowering them with the skills of addressing decision makers, they would be better stimulated, and their work would be more effective. Unfortunately, HP is not included at all in the training of teachers, consequently in most of the important action fields: schools - it is not really present.

A researcher from the Netherlands shares their professional concerns, "I think being a health promotion specialist is (wrongly) not seen as a 'real' profession. The field is also dominated by researchers who will be in the field for a short period. Practice based knowledge is underestimated."

Another Dutch researcher and health promoter questions the current competencies of health professionals. "Health professionals have too little knowledge of the importance and preventability of behavioral, social and environmentally related health risks and are not adequately supported to take that up."

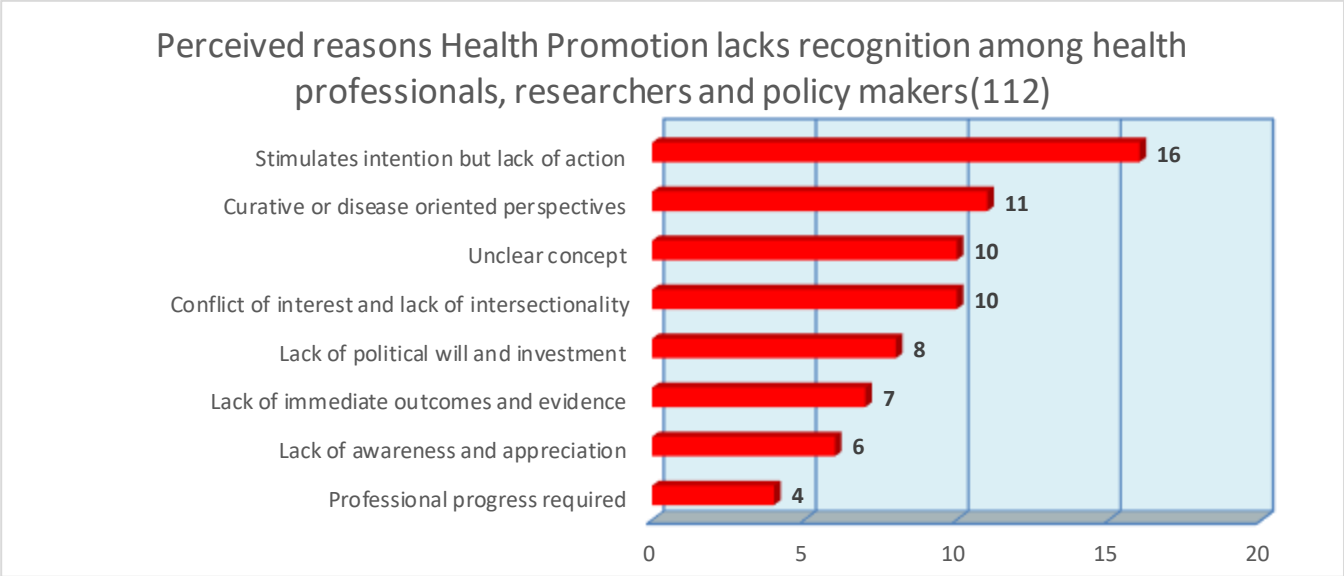

Figure 19: Perceived reasons influencing Health Promotion's lack of recognition among health professionals, researchers and policy makers

5.4 b HEALTH PROMOTION RECOGNITION AMONG THE PUBLIC

40% of survey participants declared that HP is known, understood and valued outside the public health field among the public. 32 of 111 of respondents supported the awareness of HP among the public and stated reasons such as: Health conscious citizens and stakeholders (11), Effective intersectoral collaboration (10), Increasing awareness and impact (8), and Setting and field dependent (3). The remainder of participants (79 of 11) provided factors that may be contributing to a lack of health promotion recognition among the public. Open coding was used to develop meaningful units and answers were organized into categories. Responses contributed to the understanding of exploring the perceived value of Health Promotion.

Factors positively associated with Health Promotion recognition among the public

Health conscious citizens and stakeholders (11)

11 respondents perceived that citizens and stakeholders are now more conscious of health and its "social, individual and financial impact." "All stakeholders are now interested in health," shares an Italian researcher while a Dutch manager of epidemiology and health promotion states, "more and more health is valued by other domains." One health promotion researcher from Italy emphasizes that "there is more and more interest of others to integrate health /health promotion in their activities or at least to consider the impact it could have on the health of the population." A curative/palliative care worker from Portugal reflects that "personal and community health literacy is gradually increasing and Health Promotion and illness prevention is now a greater concern for general people."

Though the health promoting consciousness exists, there is still some doubt regarding its impact. As one Health Promotion researcher from Denmark states, "Politicians are aware of the socioeconomic advantages of health promotion, but I cannot say how far that interest stretches. However, free newspapers often lead with stories that relate to public health, suggesting that "health" sells newspapers." A Canadian researcher and public health practitioner offers their perspective:

> I think promoting health is widely accepted and becoming more acceptable every year in Canada but whether or not it is good public and population health promotion is another question entirely. From what I see in Europe, Health Promotion practices and principles are on very different trajectories in every country, with many countries in Eastern and Central Europe having very little, so more discussion is needed among health professionals.

Effective intersectoral collaboration (10)

10 respondents provided statements that collaboration between sectors has in some way been successful and "needs collaboration between different fields." A researcher and educator in Australia with 30 years of experience stated that "intersectional action has been effective and other sectors are taking over health promotion." A public health practitioner from Italy shares that "other professionals, not health ones, use health promotion techniques and help people to develop personal skills" while a health promoter from Italy perceives that "schools and associations are very well involved." An educator in the United Kingdom shares that "it (Health Promotion) is widely understood within the health and education services, but also in several other sectors of the economy" while a public health practitioner from the UK states that a "wide range of professionals discuss health promotion at national and community level."

A public health practitioner from Norway further reflects on the necessity of intersectoral collaboration:

> Through regular cooperation we see that health promotion is becoming increasingly important also in the other sectors. We see how important it is to cooperate with the others and create awareness. within health care, we will not make it without the others also will do their parts.

Increasing awareness and impact (8)

Several responses (8) revealed that awareness around Health Promotion is increasing "more and more so" and is known "because of its impact on several levels." One public health practitioner states this connection may be to "mass media like TV, radio and newspapers." An educator in Norway shares that "the concept of Health in all policies has gained increased understanding over the last years." Though an increase in awareness and impact is stated, about 4 participants shared that this is "to an extent" or it is still not enough. Though "health promotion is known, it is not always understood in full range." Or, as a UK researcher perceives, "it is not clear it is valued as it should be (by politicians) when there is little dedicated funding left."

A health promoter and public health practitioner from Portugal also points out that though awareness and attitudes in health promotion is there, but it is not enough:

> Large population campaigns and education programs have been successful in increasing awareness, knowledge, in creating attitudes and values towards healthy lifestyles, but actual behavioral change has not been achieved in a cost-effective manner or, if it does, we still don't know. For the appropriate delivery of those projects, it is important to evaluate them, in order to assess whether the project has met its objectives and has been efficient and effective in their purposes.

Setting and field dependent (3)

3 respondents believe that public recognition of Health Promotion depends on the setting and field in question. A researcher and educator from Austria recognizes that Health Promotion is present in some companies and workplaces. Another educator and health promoter from Austria agrees that "it depends on the setting and the field" while a Swedish researcher believes that in some areas it is recognized and is "for example one goal for the school health organization."

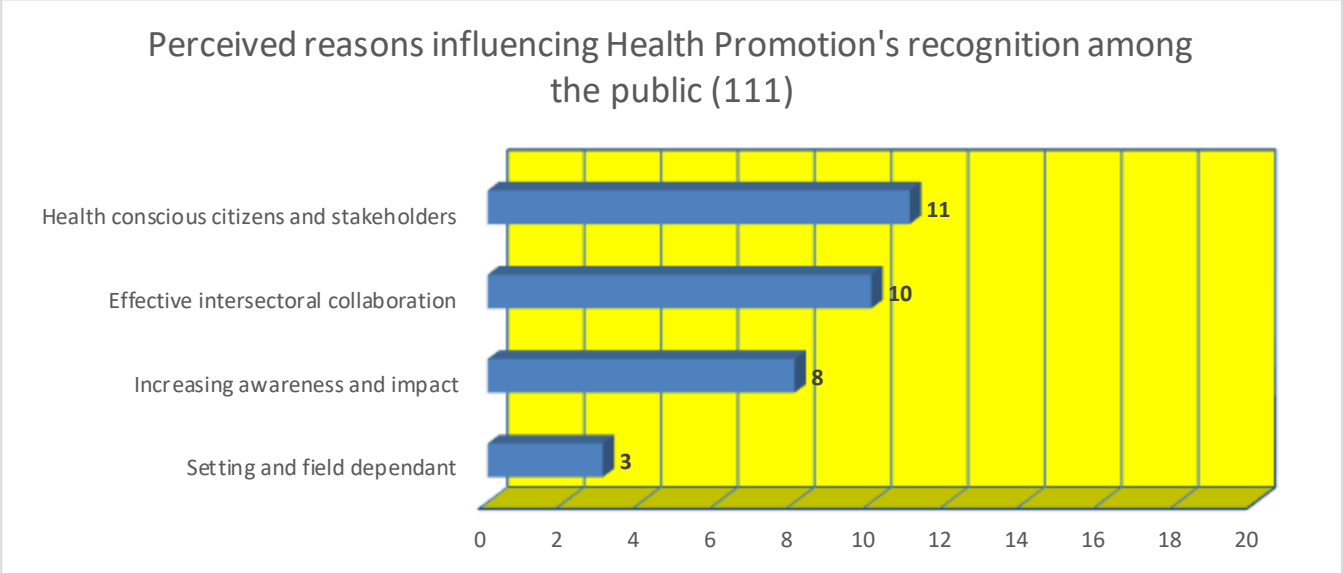

Figure 20: Perceived reasons influencing Health Promotion's recognition among the public

Factors negatively associated with Health Promotion recognition among the public

60% of respondents for this question believed that health promotion is not well known and valued among the public (*Figure 17*) and 79 of 111 of those provided their opinion regarding factors influencing this: Unclear concept (20), Low awareness (14), Curative/disease oriented perspectives (12), Lack of political and intersectionality (10), Lack of immediate outcomes and evidence (8), Lack of value (7), Behaviour change (5) and Professional progress required (3).

Unclear Concept (20)

A total of 20 respondents felt that as a concept, there is a lack of understanding or confusion around Health Promotion, affecting its potential to be better known and recognized. “It is not well understood,” shares a Health Promotion researcher from Spain with over 30 years of experience. “The introduction of the concept and practice is slow despite having a good General Public Health Law that include the general ideas about health promotion and HiAP.”

Though the awareness of the concept is growing, its general use in many fields is also seen as problematic. As one health promoter and public health administrator working internationally explains:

> I think one issue is that nowadays the term is used within so many fields - in some ways this is a very good / helpful thing but then the dominant focus may end up being that which is most numerous e.g. sport / leisure interpretation / application focused on individuals rather e.g. than policy change.

Another respondent adds:

> Outside of the Public Health field, the number of persons and institutions that have an idea of Health Promotion is growing. Often their topics are oriented to "Health Education" or "behaviour change"; seldom they have topics like "Change the Determinants.’

Some participants shared that the terms prevention and promotion “are often used synonymously,” thus adding to the confusion. An Austrian health promoter perceives Health Promotion to often be “mixed with prevention” while an Italian researcher and educator stated that there is “a lack of knowledge and a misunderstanding about difference between prevention and health promotion.” This gap is also seen when discussing either the concept or practice. As one participant states:

> The concept is about health, and often about health in a broad sense making health promotion deal with (or intrude) on many areas of people's lives. The practice is often difficult to distinguish from disease prevention, since focus often is to address risk factors for diseases.

Various concerns were presented regarding the concept of Health Promotion. A public health practitioner from Sweden reported that “it (Health Promotion) is understood as too superficial and narrow,” while a researcher from the Netherlands believes that “in general outside the field, health promotion is not a clear concept and is considered a weak way of influencing health.” This lack of understanding is seen as affecting HP’s potential impact. “If health promotion was truly understood,” shares an Austrian researcher, “then it would be used more often and more effectively.”

Low awareness (14)

Low awareness of Health Promotion was identified in statements of 14 survey respondents. An educator from Belgium perceives Health Promotion to be “not well known, and if known, very stereotypical ideas.” A researcher from Denmark points out the “lack of knowledge” surrounding HP, while a researcher from Nigeria agrees that “awareness is very low.” This lack of awareness extends to professionals in the public

sphere. An educator from Bulgaria believes this extends to other professionals and states, "According to data from our study, professionals in the country are not well acquainted with the concept of Health Promotion." A public health practitioner from France agrees that "even health professionals are poorly aware of it (HP)" and a Finnish researcher observed that "many professionals have a quite narrow opinion or view about what is the Health Promotion."

A few reasons are offered for the perceived lack of awareness. A health promoter and educator in France reflects on this lack of awareness. A health promoter and researcher from Israel in the field for 30 years shares that "there is not enough mass media action in this field and in the parliament." A prevention care worker and researcher from Georgia sees how exterior issues impact the popularity of Health Promotion. "In my country, Georgia, Public health is not very popular field due to other social and political problems, accordingly health promotion is not well known." Another prevention care worker from Georgia continues, "only few people who got an appropriate degree in university of Bergen knows role of Health Promotion, but most public health professionals still counts that it is part of public health." Even though there is a "general awareness", according to a researcher and educator in Italy, it is "not enough." This is because "in terms of how Health Promotion is done and how it should become "a way of thinking" there is still a lot to do."

Curative/disease oriented perspectives (12)

12 participants indicated that there is a greater spotlight on the cure, disease, medicine and clinical thinking in the health sector which overshadows the need or awareness for health promotion.

Public perspectives continue to be oriented towards the curative mindset, as opposed to prevention. A researcher and educator in Denmark states: "the health sector is dominated by a medical perspective in my country. Health promotion is loosely defined, and the term is rarely used. Instead people talk about prevention in a more medical paradigm." A researcher in the United Kingdom elaborates by stating:

> When people think of public health in this country, they think of the "medical model" based on epidemiology and prevention of disease. They don't know about health promotion, and many think it is just health education (which doesn't work)." A health promoter and researcher from the Netherlands shares that "people still believe that health risks will not harm them and that the doctor will cure all.

An Italian researcher observes how this perspective is also dominant among healthcare professionals "who consider the cure more important than prevention." A researcher in the UK and Canada suggests the need to expand the perspective of health beyond health care. "I feel the general public thinks of health as health care, not all of the social, economic, political and physical aspects of the wider environment that influence health (i.e. public health/population health/health promotion."

In practice, health promotion is also seen as "mixed up with disease prevention," according to a researcher in Germany. A researcher and educator in Portugal continues that "thought and action outside of the public health field is mainly centered in pathogenic orientation, seeking to avoid the disease, treat the disease and its

complications and rehabilitation." A prevention care worker and health promoter in Belgium offers their view on why this may be:

> Health promotion is still vague for most of the population. And also among the public health sector. The prevention of diseases or problems still prevails. Few professionals take a real positive perspective on health and well-being especially in the research field. In my opinion, I think researchers prefer showing number of disease or negative health status decreasing rather than improvement in wellbeing which is harder quantify.

Budget is also seen as a potential contributor to curative perspectives. As a health promoter in Netherlands observes, "there is much more attention and budget for care and cure." A curative/palliative care worker in Spain perceives that Health Promotion offers "no business" and the "mainstream of medicine is oriented to gain."

Lack of political will and intersectionality (10)

10 respondents shared reasons for a lack of recognition of HP in the public having something to do with political and organizational barriers. Health promotion was identified as "not politically popular" and in some countries, as indicated by an educator in Kosovo, there is "not enough political will" to put Health promotion higher on the platform. A researcher and public health practitioner from Italy and South America notes that "You may find interesting initiatives at local level, but no political willingness to seriously promote health, safeguard the environment and people's lives." A curative/palliative care worker from Brazil suggested that health policy is specific according to "market demands" and noted the "restricted social participation of the population" as a challenge.

Organizational challenges in mainstreaming Health Promotion are also observed. One participant shares that it may not be that HP is "disregarded," but rather that "it is very different to align different drivers of our societies towards the same goal." An educator in Greece believes that "there has never been a really organized effort to a large country extend" while a researcher in Kosovo feels that "deficiencies in communication" is part of the problem in their country. A public health practitioner in the Netherlands adds that "intersectoral cooperation is not always easy to organize." A researcher in Denmark expresses similar notions by stating "There is no direct connection between Public health knowledge and health promotion initiatives. These are often funded by "pools" lasting only few years, and the agents (dansk: kommunner, regioner, stat) only work together at a superficial level." A health promoter and researcher in Switzerland observes that "its (Health Promotion's) political and social aspects, linked with the social determinants of health at broader levels of society, remain unrealized/not yet consciously and systematically applied.

Lack of immediate outcomes and evidence (8)

"No immediate outcomes" in the field of Health Promotion is seen as an issue among 8 participants. A curative/palliative care worker in Portugal suggests that "the issue is that policy makers don't value preventive interventions because they have no individualized targets and request immediate expenditures with delayed results." A health promoter and researcher in Portugal agrees by stating that the "politicians don't see the results immediately." Another health promoter in Portugal reveals:

> There is always a lapse of time between the interventions in health promotion and the first results/impact and, sometimes, if the evaluation of the interventions is poor and/or inexistent (often is), it's difficult (impossible) to draw a relation between the intervention and the results/impact.

A prevention care worker in Scotland points out the advantages of HP, but also notes the trouble of long term results:

> Health Promotion is known and understood due to the large amount of research conducted on it, however I do not think it is valued out of the Public Health Field as much as it should be. Health promotion would help resolve many of the issues facing our health care system (A&E waiting times, increased chronic conditions, staff burnout, staff shortages) however it produces long term results, and therefore does not receive priority over actions which produce quick short-term results.

Lack of immediate outcomes in experiencing the effects of disease are also mentioned. A health promoter and researcher and Switzerland points out that "only people who have had health problems understand the importance of health promotion." With regards to evidence, a researcher and educator in Austria expresses concern over the lack of controlled trials, and focus on qualitative methods. "There has to be a balance in quantitative and qualitative outcomes."

Lack of value (7)

8 responses expressed a lack of value associated with Health Promotion, affecting its recognition in the public sphere. A few respondents even perceived HP to not be valued within the public health field. "Even within public health it is not valued. And the people outside of public health who value Health Promotion concepts and ideals may not even know it is called health promotion," shares a health promoter in France. An educator in Slovakia continues, "In general no, health promotion is not understood by other sectors, sometimes is not understood even in public health area. What we missed are leaders in Health Promotion, cooperation between academia and practice." A researcher and educator in Denmark feels that this lack of value is reflected in the lack of research funding or positions in the field. A prevention care worker in Austria reflects, "the fact that only 2% is spent on prevention in Austria, which is less than the OECD average, and the fact that we also have below-average growth in the field pretty much says it all." A health promoter in Germany feels that "there still seems to be a sharp drop in understanding and value placed on

health promotion between those working in the field and those outside." As a researcher and health promoter in Finland suggest, "It (HP) is known, but could be more understood and valued."

Individual behavior change (5)

Five individuals identified that HP "is associated with individual behavioral actions related with lifestyles" and is an aspect of HP that is difficult to approach or measure. "Many people think it is individual responsibility," states a public health practitioner in the Netherlands while a health promoter in Austria believes that "it's (HP) is reduced to promoting the right individual behavior. A researcher in Germany continues by stating that "the practice (HP) regularly focuses mainly on the individual changes not on community or policy changes."

> A prevention care worker and health promoter in Portugal share their observations regarding this challenge: Large population campaigns and education programs have been successful in increasing awareness, knowledge, in creating attitudes and values towards healthy lifestyles, but actual behavioral change has not been achieved in a cost-effective manner or, if it does, we still don't know. For the appropriate delivery of those projects, it is important to evaluate them, in order to assess whether the project has met its objectives and has been efficient and effective in their purposes.

A health promoter and researcher in Switzerland believes that wider determinants are less understood than individual responsibility for health. "As I see it, Health Promotion is frequently understood with an individual responsibility for health and the prevention of diseases, not with healthy public policy on aimed at improving community action, environmental conditions for health and social determinants of health."

Professional progress required (3)

Three individuals described the notion that there is a need for professional progress for Health Promotion to move forward. A health promoter and public health practitioner in the UK describes the reputation around HP by stating it is:

> Often seen as the lesser sector in terms of regulation, codes of practice etc. More work needs to be done on defining health promotion practice - too many companies. people, practices adopt the name- also often seen by the public in a negative (nanny state intervention).

A researcher and educator in Bulgaria also identifies the professional gaps by stating that "there are no practical approaches for its application in my country." There was a belief that "there should be more active involvement of other professional fields" towards HP use and that health professionals are "underactive in promoting HP. Meanwhile a researcher and educator in Ireland feels that there are already many players playing a role in HP and sometimes that is part of the problem:

> There are many agents who play a role in Public Health, accentuating the links in the chain (the nodes) and the manner of information flow between the various links. Charting of these areas in a formal visual would aid in both spotlighting individual professional and contributors' roles while also providing an overview of the bigger picture. In clinical practice, we can have multiple disciplinary

teams in determining the overall approach to patient care. In public health, this also occurs but perhaps is less clearly understood by some players. We map Europe, the cities, the transport systems, country boundaries. Most people have some aspect of a visual map of Europe in their mind. Why not a map of Public Health process.

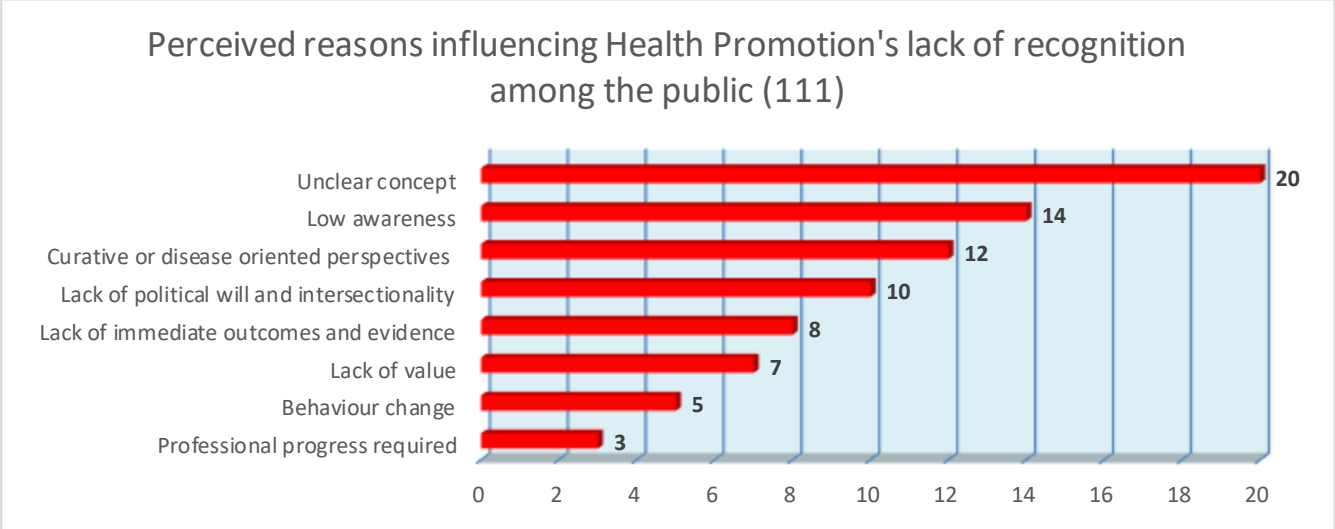

Figure 21: Perceived reasons influencing Health Promotion's lack of recognition among the public

5.5 WHERE DOES HEALTH PROMOTION STAND?

Participants were given the opportunity to give their opinion on what they perceived to be strengths and opportunities for Health Promotion, as well as what they enjoy and found challenging. 122 participants shared what they perceived to be strengths and opportunities for Health Promotion while responses among 69 participants included what they found challenging. Open coding was used to develop meaningful units and answers were organized into categories. Responses contributed to the understanding of exploring where Health Promotion currently stands among health professionals and beyond and are presented in both *Figure 22* for perceived strengths and opportunities and *Figure 23* for perceived challenges.

5.5 a PERCEIVED STRENGTHS AND OPPORTUNITIES FOR HEALTH PROMOTION

122 participants responded to the open question asking them what they perceived to be the strengths and opportunities for Health Promotion. Most respondents believed that Health Promotion represented Positive vision and values (18), followed by Individual and community potential (17). Categories of other statements included that HP Promotes social responsibility for health (16), Health and social benefits (15), Provides opportunity for expansion and collaboration (12), Asset based and sustainable principles (12), Addresses root causes and prevention (11), Tackles inequalities and health threats (9), has Professional potential (6), and promotes Improved settings and systems (6).

Positive vision and values (18)

One of the perceived strengths of Health Promotion as identified by 18 survey participants is its opportunity for embracing a positive vision and positive values. Health Promotion was identified as a "holistic approach" and a "global vision" by many of the participants, one focusing on "life realities" as identified by a health promoter and researcher in Austria. A health promoter and educator in France highlights how HP is a "positive way of thinking" which trusts in people and harnesses creativity. A public health practitioner in Norway agrees HP is a "positive" approach which can change the focus of politics and professionals. An educator in Slovakia notes that the strengths of Health Promotion include the placing of "health as a value, health as a priority" and a researcher in Finland shares how it "promotes peace" and "promotes social welfare." A health promoter and educator in Switzerland perceives some of HP's strengths including "salutogenic orientation, spirit of empowerment, trust, joy of life" and its opportunity as "a new perspective of health on the people." While a health promoter and researcher in Italy believes that HP represents "health as an asset for all", a health promoter and researcher in Switzerland states that HP is a "broad, diverse and flexible field, which is open to various methodologies."

The positive impact of Health Promotion is also seen as being an essential state of mind in order to create societal changes according to a prevention care worker in Belgium. The participant states:

> I think health promotion should not be only a field but should be a new perspective to (re)think society. It should be part of the society change at each level like education (with promoting positive and active education and positive atmosphere in schools), economics (by promoting fair and local initiative), environment (by promoting healthy food, healthy work place (in term of physical environment and social environment), health care (by approaching patient globally, in their reality and letting the patient be a partner of the care giver)… Health promotion is a philosophy that can be part of every field and aiming to improve wellbeing of society.

Though the positive vision and values is evident and inspiring, it has also left a couple of participants with some doubts on whether the vision is "too good to be true." A researcher and educator in Bulgaria confesses, "I know it is a necessary field, but I doubt whether it is not a utopia. For those years I am not sure that health promotion can become a reality."

Individual and community potential (17)

17 participants shared statements that reflected the notion Health Promotion "strengthens the resources of individuals and groups" and that HP "builds on communities and social capital."

From an individual perspective, Health Promotion is seen as enhancing an individual's "awareness, self-empowerment, understanding of one's own needs, health literacy" as stated by a health promoter and researcher in Austria. Another participant perceives HP "provides the necessary conditions for individuals to

be healthy and happy" and "gives the opportunity for people to evolve towards a higher spiritual and physical level."

A researcher and educator in Ireland shares how increased awareness can build concern for others in the community:

> Health promotion offers an educational opportunity, increasing understanding of determinants of individuals and community health. It widens the population based of understanding, both allowing persons who may have not had opportunity to learn to become aware and raise awareness of new issues of concerns among other member of the population.

A public health practitioner in Italy shares how HP can "give communities back power on their lives," while a manger in epidemiology and health promotion in the Netherlands shares how "in the Netherlands, participation of citizens is central (shift of care society towards participation society)."

Perhaps an important point is that this potential is best achieved with the individual and community, and not for them, or simply a service provision or transaction. A researcher in Sweden explains how "Health promotion lets us focus on supportive and strengthening aspects in relation to health and well-being and also includes empowerment. In health promotion, we work together with the target group and not for them." A health promoter and researcher in the Netherlands elaborates by emphasizing:

> Everybody wants to be healthy but is not aware of all the aspects of health. The main opportunity lies in stop telling and teaching and start talking to people joining their perspective, coaching to reach the goals in life as defined by them and letting them feel and experience what health could contribute to reaching those goals.

Promotes social responsibility for health (16)

16 individuals stated that some opportunities of Health Promotion is that it encourages a social responsibility for health, where everyone and every system everywhere is able to be involved in promoting health in some way. A prevention care worker and public health practitioner in Greece states**:**

> I believe that the political systems and modern life place an unbearable burden on modern men, women and children to achieve balance (physical and mental) whether it is a businessman in Tokyo or a farmer in India or a migrant trying to get his family to Germany through Greece. People as individuals and as members of communities need tools, knowledge, skills and resources to maintain health. Furthermore, health promotion studies show that without equity health drops even for the advantaged members of society. We have a lot to learn from that. Solidarity, sense of community, self-help and healthy public policy systems are necessary for societies to thrive.

A health promoter in Italy reflects that "HP is an effective method to build a net of people and organizations that work together for health." A prevention care worker in Scotland shares that "Health Promotion places the responsibility of health into the hands of the people, empowering them to make healthy decisions and

live healthier lives." Another respondent continues that "Health Promotion encompasses everything that makes healthier lives possible; it is therefore involved in decisions made at every level of social organization."

Encouraging inclusive involvement is seen as pivotal in capitalizing on this strength and opportunity. A researcher and educator in Bulgaria shares how "this approach is active participation of the community and encouraging all stakeholders to improve the nation's health." A health promoter and researcher in Finland also reflects how "there are many unused opportunities in the fields outside health services. The resources of health services are limited - the responsibility of health promotion should be taken be other fields of society." An educator in Norway emphasizes "the necessity to involve all sectors of society in addressing Public Health issues" while an educator in Slovakia shares how social responsibility can be initiated "through local communities...local government...local organizations is the first step how to start and communicate to people about PH.

Health and social benefits (15)

15 respondents identified that some strengths and opportunities for Health Promotion include the wide range of health and social benefits, and various ways that it can improve the health of a population "across generations" and improve health "if used properly." "Health Promotion encompasses everything that makes healthier lives possible" states a researcher in the United Kingdom. To a researcher in Germany, not only does Health Promotion emphasize the "importance of health across the whole facets of the social and environmental determinants of life," the economic and social benefits include **"**increasing the health, well-being and quality of life in citizens of a country/region." A health promoter and researcher in the Netherlands agrees that it will "increase health autonomy, and well-being." This participant continues by stating that "It (HP) will lengthen healthy lives and reduce unnecessary healthcare costs and healthcare related damage." A health promoter in Peja and Kosova notes various strengths such as "good social relations, skilled labor power, tradition, education" and opportunities that include "palliative care, maternal and child care, elderly care, changes in policy, young population, construction of infrastructure."

Enhancing habits conducive to health are also mentioned by a health promoter, researcher and public health practitioner in Azerbaijan. They share that "benefits to Health Promotion Programs include weight reduction, promotion of physical activity, increased wellness, lowered healthcare costs, reduced rates of disease and injuries, increased productivity." A curative/palliative care worker in Portugal explains some specific and evidence-based health and social benefits derived from HP efforts:

> Increasing delivery on prevention can achieve better health in populations. If we increase the USPSTF recommended adult services from 70% to 85% over a period of 6 years in a Physician network caring for ~ 245,000 patients was estimated to have prevented 36 deaths and 97 incident cases of cancer; 420 coronary heart disease events (including 66 sudden deaths) and 118 strokes; 816 cases of influenza

and pneumonia (including 24 hospitalizations) and 87 osteoporosis-related fractures. However, there is little evidence that increased use of preventive services (other than lifestyle modifications related to diet, exercise and tobacco use and child immunization) lead to reduced expenditures. So, these facts are sound evidence that preventive efforts are very cost- effective and high value interventions that should escalate all society."

Opportunity for expansion and collaboration (12)

12 participants noted that Health Promotion has the opportunity to expand and grow outside its own field and discourse and collaborate with other organizations, people, communities, fields and sectors. An educator in Finland describes this as a "multi professional discussion and work for health" which can then allow "activating policy-makers" and thus paving a route toward collaboration. A researcher in Portugal reflects that "the local stakeholders, municipality administration, primary healthcare units, schools and associations have a major role on health promotion, even without knowing. So, if they are aware of their role in this field it is possible to target more people." Another participant believes that HP "can lead to a more effective health care system and public health policies." The respondent continues by stating that "the current climate of economic austerity forces health systems to think about ways to enhance effectiveness, there is an opportunity to join forces with the human rights and sustainable development agenda."
A researcher and educator in Italy elaborates, "HP is cross-sectional at all the field of human experience, so of public interest. With the perspective of HP is possible and necessary to address all the local and global issues about problems that affect populations and environment." A health promoter in France emphasizes that the relatability of HP draws others to connect. "We can identify with lots of other movements and causes, we attract people from many other disciplines, we bring practical and cost-effective solutions to the table."

Asset based and sustainable principles (12)

12 individuals perceived Health Promotion to be a good investment, with asset based (focus on strengths) and sustainable principles being contributors to such, as well as salutogenic approaches. One participant explains that "health promotion based on community and sustainable principles - rather than medication - is much cheaper and much more fun than any type of medication." A public health practitioner in Sweden describes HP's strength as a "universal and including strategy for sustainable development." A prevention care worker in Austria agrees that HP involves "advancing the human condition" and includes "relatively cheap interventions with wide-ranging long-term benefits (however, therefore not a "quick fix" and politically less appealing)." A public health practitioner in Italy states, "more than 75% of our health care spending is on people with chronic conditions, which are mostly preventable diseases" and believes that health promotion activities "may prevent the burden of chronic conditions (and associated costs)" while

empowering patients. Not only is prevention of diseases believed to be a strength, but HP interventions may create the possibility to prevent "civil war, displacement, aggressions, inequalities."
Focusing on strengths and the salutogenic approach was identified as an asset, as well as "the insistence on addressing social determinants of health." A health promoter and researcher in Austria states how HP has a "focus on basic health and living contexts (settings) and not on sickness and individual persons alone, strengthening a view on humanity that is in need of peace, freedom, self-determination and supportive environments." A curative/palliative care worker in Austria reflects that Health Promotion has an opportunity to "strengthen self-consciousness to engage/invest in health" and involves "knowing how to strengthen resources and enable people to stay healthy" in order to create a healthy society.

Addressing root causes and prevention (11)

11 individuals felt that addressing root causes and prevention is one of the assets of Health Promotion and includes "work outside the health sector on the cause of the causes." A researcher and educator in Denmark shares that "Health Promotion tries to change the causes of the causes rather than to cure symptoms." A prevention care worker and health promoter in Italy states that "Health promotion is a necessary tool for the prevention and to prevent is much better than to cure, also from the economical point of view." A health promoter and researcher in Israel shares: "it is an essential way to protect the populations from communicable, genetic, and other chronic diseases and disorders and gives a healthy way of life to all the segments of the communities." Another respondent believes that on top of helping people prevent or treat diseases, it eliminates risk factors for them by increasing knowledge and opportunities. Examples of such opportunities included "promotion of active living (sports, walking etc.) for all age groups, culture and art as enhancers of wellbeing, healthy eating, starting from daycare centers and schools.
Health Promotion is also seen as an advantage as it explores the root causes of issues in addition to diseases. A researcher in the UK mentions the necessity of "raising public awareness to counter the nastiness of commercial interests." A health promoter in Germany explains, HP "demonstrates the connections between social status, disadvantage, oppression and health, provides a strong logical link between human rights and health, and offers opportunities for preventing suffering and relieving the pressure on curative health services." A health promoter in the Netherlands emphasizes that Health Promotion "starts where the problems begin" and "tackle the cause."

Tackling inequalities and health threats (8)

Tackling inequalities and potential threats were recognized as a strength and opportunity for health promoters by 8 individuals. Various challenges were identified for which Health Promotion could "provide the solution to contemporary health challenges." As a health promoter in Portugal suggests, "currently the greatest threats to the health of populations can be controlled through interventions in health promotion

area." A researcher and educator in Belgium shares: "regarding the epidemiologic transition, the aging of the populations, the increasing flux of migration, the complexity and the multiple morbidity, we need health promotion to take care of these challenges."

A researcher in France explains that tackling health inequalities must go above and beyond the focus of disease. The participant states, "inequalities in health and wellbeing cannot be tackled by actions on risk factors of diseases." Where a lack of justice or equality exists, Health Promotion could also be applied. "HP is a strategy to provide more health chances for those who suffer from difficult living conditions," states a health promoter and educator in Germany and continues: "HP can contribute to more justice in health matters." A health promoter and public health practitioner working internationally describes that great opportunities lie in Health Promotion regarding health threats and inequalities:

> Huge opportunities especially as non-communicable diseases are increasing and are very amenable to HP strategies - issue is that political support can make a major difference in success. Health inequalities are a major issue - both in HICs and LMICs and HP must be better at reaching / working with lower income / disadvantaged communities.

Other specific activities to tackle such issues include "lobbying, advocating and researching "upstream" interventions. Understanding and promoting good practice (e.g. health trainers, community champions, community engagement). Speaking out against social injustice that leads to poor health and health inequalities," as suggested by a researcher in the United Kingdom.

Although the belief was reflected that "health promotion has the capacity to close the gaps in health disparities," a researcher in Britain and the USA shares their cautionary judgment. "Despite years of efforts the hope of HP and the Ottawa Charter have only partially been attained. The underlying principles and concepts of the OC are still critical. Inequity remains a global problem."

Professional potential (6)

More potential and opportunities in the development of the profession of Health Promotion was identified by 6 survey respondents. One of the strengths of HP as identified by a public health practitioner in the Netherlands is that "it is a separate discipline with body of knowledge and evidence." A researcher from Belgium notes that "it is a well-developed field with a strong multidisciplinary theoretical and empirical basis." A researcher and educator in Georgia identifies that an increasing number of individuals are seeking work in Health Promotion with younger generation learning and applying knowledge gained from programs abroad. The participant continues that opportunities include:

> Professional staff, experts from other countries for implementing updates and increasing awareness in health promotion field, to spread the knowledge about health promotion among the population to increase people awareness, to inform government officials regarding health promotion and involve them in the process.

A health promoter and researcher in Italy believes that HP should "create a real coordination of the activities, new policies and strategies, reorganization, participation, training, etc.," A public health practitioner and health promoter in the UK identifies opportunities for HP such as "regulation, codes or practice/conduct, investment(global), and technology). Other noted possibilities were "adequate and properly enforced legislation in the field" and "information and integration of Health Promotion interventions during the education of health professionals." One survey participant describes the need for more direction and practical examples for future HP practitioners. "More guides and help will be necessary from the EUPHA HP Section in order to have good practice experiences."

Improved settings and systems (6)

6 individuals shared that Health Promotion strengths include the development of improved settings and systems. A health promoter in Israel shares: "we can promote public and setting health at neighborhoods, schools, villages cities and special teams and groups." A researcher and educator in Portugal reveals that with HP there is an opportunity to "strengthen factors that promote health, reducing the costs in health systems and increasing the productivity of the population." Focus on health in the workplace, health services, and "supportive environments and infrastructures" was also identified as an opportunity for HP as well as "investment in health education activities and professional health education."

A prevention care worker, health promoter and public health practitioner in Portugal notes that in order "to improve the health of the whole population, action needs to go beyond individual behaviour change and create multilevel policy and environmental change." The participant sees this opportunity for Health Promotion while identifying the strength of HP as "systemic responses to make individual behaviour change more likely to succeed, because they recognize that factors in the broader system influence health outcomes and may create health inequities." Furthermore, a researcher and educator in Italy states, "we need to start working in a trans-sectoral way, beyond the health sector, "where people live and work" (Alma Ata Declaration)."

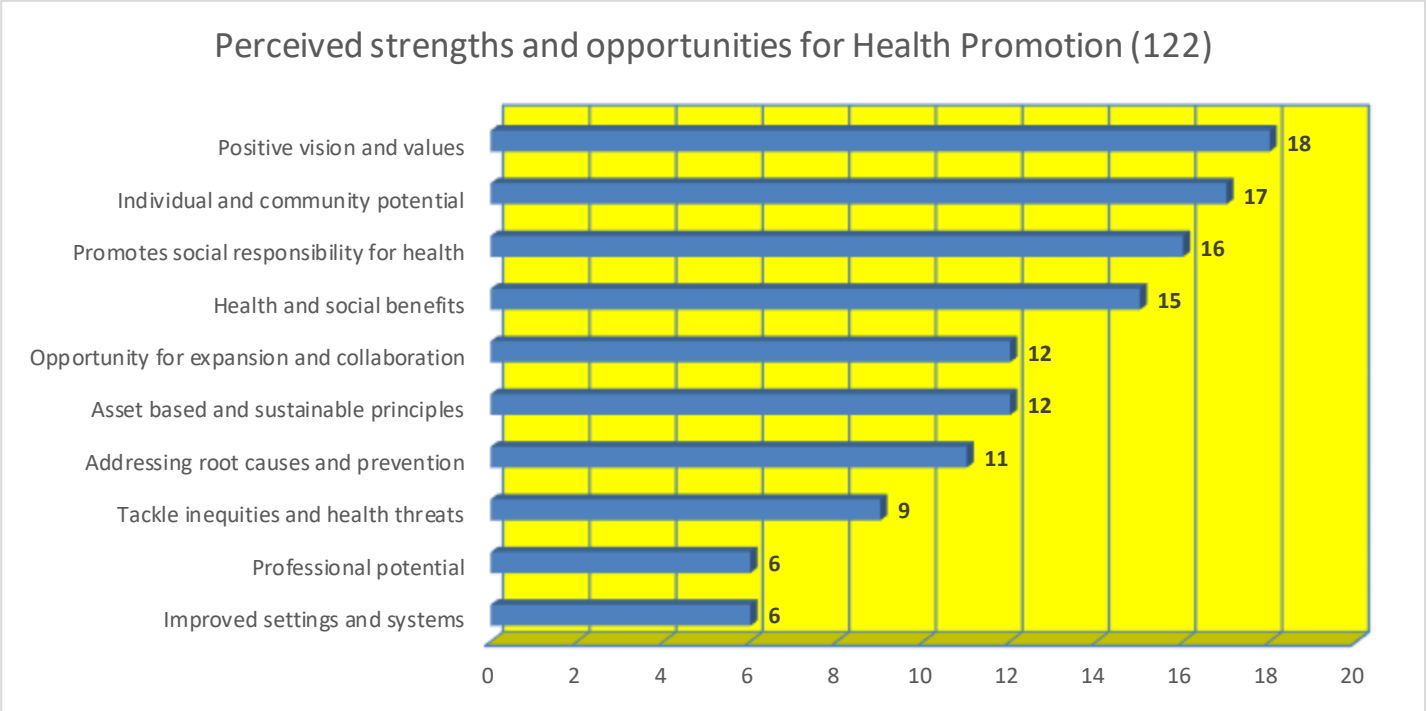

Figure 22: Perceived strengths and opportunities for Health Promotion

5.5 b PERCEIVED CHALLENGES FOR HEALTH PROMOTION

When presented with an open-ended question offering to share their opinions regarding the perceived challenges for Health Promotion today, 69 survey participants weighed in on challenges for HP theory and practice. Answers were categorized into 7 themes which included: Professional concerns (16), Sustainable and participatory approach needed (11), Political and social barriers (11), Reaching and Impacting people (10), Shift of focus required (9), Competing issues and interests (6), and issues around Advocacy and visibility (6) as observed in *Figure 23*.

Professional concerns (16)

Professional concerns was one of the top perceived challenges identified among 16 of 69 HP professionals who expressed their opinion in response to this open-ended question. As a researcher and educator in Belgium shares, there is a "gap between theory and practice: we need to improve implementation and evaluation of the actions. Need to better include the intersectionality of the factors of social exclusion and multilevel approach." A health promoter in France identifies that the demographic within the field may pose a problem. "I enjoy the community but it has an age problem...between students and those on the cusp of retirement there is a big gap." Other participants gave suggestions of how EUPHA could play a more active role in addressing professional concerns. High professional conference fees were presented as barriers towards participation for low income countries, students, or professionals experiencing financial hardship.

More democracy within EUPHA in terms of nominating its leaders and choosing conference titles was also mentioned.

A researcher and public health practitioner in Canada reflects:

> I'd encourage EUPHA to examine and delve further into what specific member PHAs are working on or prioritizing in their countries for health promotion and public health (perhaps a map of top three priorities of each member). I think we'll see some similarities and differences but also how each country is tackling health promotion and what are their priorities. One opportunity would be match different members up working on the same priorities to further sharing of best practices especially in the area of advocacy, which is complex.

The participant also shares the difficulty in working alongside those whose expertise does not lie in the field of HP or policy making. "As a health promoter, I enjoy working on health promotion policies and legislation, but I find it challenging working in an environment with medical and clinical experts who have little experience in policy-making or issues related to public administration, which are key to make significant inroads in healthy public policy and change." A health promoter and researcher in Romania shares "it's a challenge the lack of budget, lack of volunteers and the heavy mentality / resistance to prevention of Romanian medical staff/students who is focused only on clinical specialties." The respondent suggests, "why we don't have unique standards and also similar university license programs for Dietitians in Europe?" An educator in Slovakia believes that "it would be very useful to build HP education system in EU and HP workforce /standards for professionals at international and also national level through academia and postgraduate education." Another respondent suggests it would be useful to "create a free bank of health programs" which could be easily found and replicated while another suggests creating "research specific groups."

Sustainable and participatory approach needed (11)

11 participants identified that a more sustainable and participatory approach is needed as it can often be a challenge in HP. One participant mentions that actions must happen on all levels to improve family health, the need for more empowerment and participation and community-empowering programs. A paternalistic approach was noted in the public health and education sector which may hinder authentic participation. A public health practitioner and prevention care worker in Greece shares:

> I value your work, I only wish it develops in my country (Greece) which is facing several challenges where a health promotion point of view would be more beneficial than an austerity biomedically based health system or even a "prevent outbreak" kind of mindset.

A prevention care worker and health promoter in Belgium shares:

> I think that there is still a huge need in changing the paradigm of health promotion. The public health sector and education sectors (universities) still take too much a preventive approach that they call

> health promotion, and still take a paternalistic approach by setting the objective they think are good for people. More emphasis and research should be given to the positive perspective of Health Promotion.

Changes in this area and mindset were perceived to ensure a more inclusive growth in HP, as well as returning to the rots of HP's message and vision. "I think the challenge is to remind us about what the Ottawa Charter stated, that the concept sometimes is misunderstood and used instead of prevention," states a researcher in Sweden. Making contact and engagement versus educating was also mentioned as a challenge by a health promoter and researcher in the Netherlands:

> I strongly believe that every human being wants to reach some life goals and that this is the big motivator in performing a certain life style. I would like to promote the art of making contact rather than trying to educate people and persuade them to a life style we as professionals think best.

Sustainability of projects was identified as difficult as results often take a long time to be observed for people and politicians and often get lost in the implementation process. Another important consideration for a sustainable and participatory future was "finding the right way to convince non-involved persons to become health actors."

Political and social barriers (11)

Political and social barriers was a category that captured the challenges of 11 participants. "Hidden policy agendas" was identified as political barrier as well as "lack of political will," and another participant feels that "health in all policies needs to be promoted on the EU level." A health promoter and researcher in Austria however, believes holding back on the political focus might be the key and states, "please hold the political view of health promotion and investigate the basic view on humanity incorporated." A health promoter and educator in Denmark expresses the challenges of creating change on both the municipal and national level:

> I find the national level challenging - it is all about what you can do -- blaming the victim. We have so must knowledge, evidence and so many reports, but....no one seems to dare to implement it in its full. I work in a municipality and I find it very challenging that so many things that really could make a difference for the citizens has to be decide by the politicians.

A researcher working in the UK and Canada explains their challenging experiences to integrate evidence and create impact in the political realm:

> My role is more of a researcher, but the greatest challenges in building evidence for health promotion (as defined as population/public health) are developing novel methods to examine effects of policy or practice on health and on translation of results into policy action - as many of the recommendations can be controversial and require regulation or government led action.

Another participant continues, "the challenge is the difficulty in collaborating with other figures from different economic and administrative sectors, and, in Italy, the lack of founding and of job opportunities for young health promoters." A researcher in the UK identifies social barriers as well by stating:

> Some areas face great barriers for one or another reason (faith issues, commercial interests, plain ignorance, etc.). I find these challenging and feel the need to produce and disseminate evidence to counter the barriers - and train students to do so as well.

A curative/palliative care worker in Portugal also suggests:

> I think the original idea of health promotion in Ottawa declaration should reviewed and updated according to the modern healthcare setting and evidence of cost-effectiveness should be the track to persuade policy decision maker to engage more on health preventive/promotion interventions as a tool to improve population health outcomes in sustainable way.

Furthermore, to change political and social climates, there was an identified need for the sharing of experiences, expertise, collaboration, research and joint projects with other health promoters in different settings.

Reaching and impacting people (10)

The issue of "reaching people" and "convincing them" was identified among 10 individuals. Making sure that the population is informed and having a significant enough impact for policies to be created was a challenge for a curative/palliative care worker in Albania. "As a health promoter, I find challenging getting the population informed about it (especially for diseases that might have a better ending through prevention) and creating healthcare policies". Another participant agrees that "the challenge is to increase citizens' access to the knowledge of health promotion and disease prevention, and create mechanisms for participation and social control carried out by the own population." The challenge in "getting medical professionals on board" was also an identified struggle on top of reaching and impacting the population and politicians. The issue of applying and recording impact of HP projects in developing countries, and incorporating research of developing countries, was also presented. Reaching and impacting populations was not limited to minorities and underprivileged populations, as age was also seen as a factor. "I think it is very challenging working with people of every age and helping them to be active in promoting their health," states a health promoter in Italy. Furthermore, the struggle of "getting the message out there" was identified as tricky as not only are there are varying and diverse needs and environments, but "it is very hard to find those population groups that need health promotion the most." In order to reach and impact more people, it was also suggested to "use simple words to make it health messages clear for all."

Shift of focus required (9)

9 participants identified suggestions to address challenges that would require a shift in thinking or perspective within HP. Suggestions to create more focus in the arts within health promotion as well as implementing cultural approaches was mentioned. A researcher in Indonesia states:

> Cultural things are the most challenging issue I ever had. Different culture created different challenge for me as health promoter. We cannot generalize all individual or groups similarly each other and not all values from our perspective is correct based on their culture. I am very exciting to learn more about practical culture approaches to be implemented in health promotion and health promoter needs to learn in appreciating cultural differences.

A researcher in Denmark points out that there needs to be "more focus more on ethical aspects of health promotion." A researcher and educator in Italy continues with their own observation:

> I think that primal health (pregnancy, childbirth and early childhood) need to be addressed. There is a poor awareness, even within the scientific world, on how the primal period affects health lifelong… We need to promote health from the very beginning, primum non nocere approach.

A health promoter and educator in Switzerland highlights that there must also be a shift in our health discourse. "Too often, people use the terminus "Gesundheit" (health), but in fact they talk about "Krankheit" (disease, illness) and treatment. We must understand and push the "double continua model" if we postulate that health is not the absence of disease." A health promoter and researcher in the Netherlands states, "I am a strong promotor of the positive health concept. I would strongly recommend the EUPHA on stimulating this new approach since the deficit-approach is no longer the leading (but still an important) principle in the present and future world." "Health Promotion in primary care" and "active patient involvement" was also seen as an area needing greater focus as well as "more work on structural determinants of health and health equity."

Competing issues and interests (6)

6 participants perceived that one of the challenges of HP is that there were various competing interests and issues which may hinder its progression or accomplishment of certain HP related goals.

A researcher and educator in Bulgaria shares that "at the EU level they are not talking actively on this issue and there is no funding for promotional programs." Another participant introduces the challenge that HP is "competing with other "urgent" clinical needs for funding," while another shares that "challenges are structural issues and ongoing cuts on services particularly on social prescription programs due to austerity measures." A health promoter and researcher states:

> Most challenging to me is that health promotion discourse is strongly overshadowed by other health-related discourses (e.g. neoliberal, biomedical, epidemiological) once policies are being put into

practice." Because of competing interests, "collaborating with economic and administrative sectors" is challenging as well as "lack of funding and jobs for young professionals.

Advocacy and visibility (6)

One of the challenges indicated among 6 participants was though they enjoy contributing to the field, there is an issue of advocacy and visibility. The issue of how to best advocate for HP was a concern, especially since sometimes HP and HP research is unknown and appreciated. One participant shares their challenges "being visible and attracting resources." A prevention care worker in Scotland shares the joys and struggles of the visibility of health gains or lack thereof in their research. "I also enjoy being able to see the effects of our health promotion projects across communities by looking at data over the years and watching injury rates decrease in those communities. Sometimes, despite a successful campaign, the dataset does not indicate positive change and this can be frustrating, as I know data has its limitations and does not always mean there hasn't been positive change. Because we cannot see the direct results of our work, it can be difficult to stay motivated that what we do is making a difference."

A curative/palliative care worker in Portugal believes that advocacy for HP must focus on highlighting its value in order to be better known, versus the goal of cost savings. "What should be considered in the social marketing campaigns is emphasize what value preventive measures can achieve. From that perspective health promotion and disease prevention can provide high value to society by improving lives at relatively low cost and, when confronted against treatment, have a better chance of providing a good return on investment."

A health promoter and researcher in Spain suggests that told be developed for European Public Health Advocacy. "It is worth having an active group that makes constant activities to place health promotion in the European Media and Political Agendas."

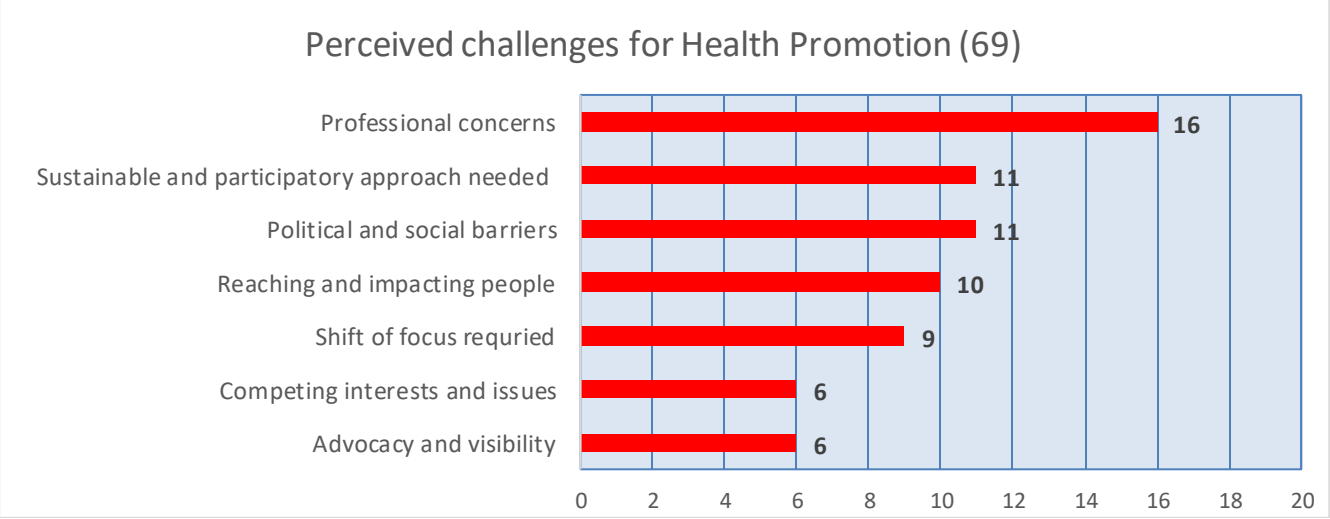

Figure 23: Perceived challenges for Health Promotion

5.6 FINAL THEMES AND CATEGORIES

5 core themes emerged as a result of qualitative inquiry results which best organize and describe the data that captures the opinions of Health Promotion researchers and practitioners on the essential aspects of perceived relevance of the Ottawa Charter and Health Promotion principles: Concept, Potential, Barriers, Practice, and Impact, as observed in *Figure 24: Final themes and categories*. As described by Creswell (2013), the central elements of qualitative data analysis require the process of coding and condensing the data, organizing them into meaningful segments, then combining them into broader categories and themes to be displayed in a table and further described. Answers with similar categories were combined or grouped together and data from yes/ no questions in the survey were also merged into these categories for further description and discussion. Along with identifying the successes of Health Promotion, factors deserving greater attention were also highlighted. These major themes also gave insight to the overall research questions:

1 What is the Ottawa Charter and Health Promotion?
2 What progress and changes have occurred globally and within the Health Promotion field since the Charter has been introduced?
3 How have the Charter and Health Promotion concepts and practices been applied?
4 Is the Charter known and still relevant in today's context and where does Health Promotion stand?

Core themes	CONCEPT	POTENTIAL	BARRIERS	PRACTICE	IMPACT
Research Questions	1. What is the Ottawa Charter and Health Promotion?	2. What progess and changes have occurred globally and within Health Promotion since the Charter was introduced?	2. What progess and changes have occurred globally and within Health Promotion since the Charter was introduced?	3. How have the Charter and Health Promotion concepts and principles been applied?	4. Is the Charter known and still relevant in today's context and where does Health Promotion stand?
Categories from Qualitative statements	Positive vision and values (18) Holistic and positive vision (10) Promotes social responsibility for health (16) Asset based and sustainable principles (12) Unclear concept (10)(20) **Personal definitions**: Individual and community empowerment (19) WHO/Ottawa's definition (18) Supporting and creating healthy lifestyles (15) Health education, knowledge and skills (15) Supportive environments (12) Health maintenance and improvement (12) Overcoming health threats, barriers and root causes(10) Improving structures, systems and determinants (10) Positive health, wellbeing and quality of life (8) Prevention of diseases (6) Shared responsibiliy for health (4) Difficult to define (3)	Individual and community potential (17) Increasing health interest and concern (14) Health conscious citizens and stakeholders (11) Progress of HP presence and importance (4) Setting and field dependent (3) Intention but lack of action (16) Sustainable and participatory approach needed (11)	Curative/disease oriented perspectives (11), (12) Political and social barriers (11) Lack of political will and intersectionality (10) Conflict of interest and lack of intersectionality (10) Lack of political will and investment (8) Competing issues and interests (6) Lack of immediate outcomes and evidence (8),(7) Behaviour change (5)	Provides opportunity for expansion and collaboration (12) Effective intersectoral collaboration (10) Shift of focus required (9) Complementary to other roles, fields and sectors (7) Advocacy and visibility (6) Professional concerns (16) Professional potential (6) Professional progress required (3)(4)	Health and social benefits (15) Addresses root causes and prevention (11) Reaching and impacting people (10) Tackles inequalities and health threats (9) Increasing awareness and impact (8) Improved settings and systems (6) Multi-level impact (5) Low awareness (14) Lack of value (7) Lack of awareness and appreciation (6)
Quantitative content		Perceived progress of Health Promotion		Perceived use of the Action areas	Perceived value and recognition of Health Promotion

Figure 24: Final themes and categories

6 DISCUSSION

6.1 METHODOLOGY

The following results will be discussed in light of the five core themes that emerged through qualitative inquiry, the categories deriving from participant statements and meaningful units, along with their connection to the research questions and the quantitative content from the survey analysis. These results will also be described and contrasted while considering the literature surrounding the topic. The structure is organized in *Figure 24:Final themes and categories* and will be discussed in greater details in the following section.

6.2 CONCEPT

The theme of Concept was most related to the research question exploring "What is the Ottawa Charter and Health Promotion" with various categories highlighting the positive and holistic characteristics of the Ottawa Charter and Health Promotion principles, lack of clarity surrounding the concept, and categories exploring the personal definition of Health Promotion.

When asked to define Health Promotion, participants shared various aspects which they perceived to be central to HP as seen in *Figure 8*. Many of these aspects are action-oriented and highlight HP as a positive concept that has potential to drive change to make improvements, educate, support, maintain, share, prevent, overcome and empower. Similar language was repeated in participant responses throughout the study which would illustrate HP as a strong and positive concept.

Though many participants attempted to define Health Promotion, it was evident in this study that though Health Promotion as a concept offers a positive direction acknowledging an interplay of determinants requiring attention, it may be simultaneously unclear. It was observed among both the participants and in the literature however, that the concept of Health Promotion as outlined in the Ottawa Charter presents a better understanding of the various factors that influence population health. As Laverack and Mohammadi (2011) express, "since the advent of the Ottawa Charter, health promotion strategies have taken a more holistic approach based on a better understanding that diseases are caused by a complex interaction of factors including social and political determinants" (Laverack & Mohammadi, 2011). It is also apparent among responses that the concept calls upon collective action and social responsibility to cultivate the conditions necessary for this approach.

However, aspects of the Health Promotion concept continue to be unclear for those outside the umbrella of Health Promotion. A Swedish study among health professionals in primary care and hospital settings interviewed practitioners about their willingness to engage in more Health Promotion. They found that there

are "different interpretations of what constitutes health promotion and the relationships between health promotion and disease prevention" (Johansson et al., 2010). The researchers introduced that:

> Health Promotion is normally understood as a measure that is based on knowledge of what promotes good health, so-called healthy or protective factors. A mobilization of these factors leads both to increased resistance to illness and to faster recovery from illness. Disease prevention is based on the knowledge of what causes ill-health, so-called risk factors. The aim is to prevent specific disease or injury" (Johansson et al., 2010).

These interpretations will likely vary according to one's knowledge, field of work and general attitudes. Even in the realm of health care alone (in clinical work, research, teaching), differentiating between health promotion and disease prevention may prove complex or confusing at times (Johansson et al., 2010). Since health promotion expands beyond the health care realm to impact unique individuals, communities and settings, the concept, though positive, needs to be sound and understandable on a variety of levels which should be taken into consideration when advocating for and "mainstreaming" health promotion. Furthermore, though the concept of HP is considered positive by many, some participants questioned whether or not it was too "idealistic" or "utopian" to implement into practice and policy. This is in line with the literature review where some authors feel that increasing health hazards require a reflection of the Charter and Health Promotion practice while for others, a greater reflection and voice is required to integrate the Charter's existing guiding principle to tackle modern threats.

6.3 POTENTIAL

The theme of Potential includes categories addressing the second research question "What progress and changes have occurred globally and within HP since the Charter was introduced?" Quantitative results from perceived progress of Health Promotion were included in this theme and qualitative categories ranged from the growing commitment to health and potential of people to the need for better implementation of ideas. These ideas were seen as requiring more involvement and input from those at the heart of the issue which best suits the environment in question and is manageable for the long-term.

80% of participants surveyed agreed that overall knowledge about the topic of Health Promotion has progressed over the past 30 years. This is in line with the findings from Ziglio et al. (2000) who maintain that "the implementation of a wide range of health promotion initiatives has generated much collective experience within Europe and added considerably to both knowledge and progressive change." Still, less than half (43.7%) of the participants felt that the field of Health Promotion was well established in their country and half (50%) felt that it is currently well established in Europe. Though there have been well-known health promotion innovations in the European region since the Ottawa Charter, with the Investment for Health approach, Healthy Cities, Health Promoting Hospitals, and Health Promoting Schools to name a

few, "there is evidence that the overall impact of these innovations has been relatively limited in the region' Ziglio et al. (2000). One has to also consider the various social, political and economic changes unfolding in European society parallel to the growth of Health Promotion (Ziglio et al., 2000) that can spur or hinder its impact in various settings.

However, through this progress, the Charter also demonstrates its potential. There is a growing health interest and concern among citizens and stakeholders while the Charter promises to lift individuals and communities to greater possibilities of health and social wellbeing and experience its benefits. As one study participant explains:

> Health promotion can encourage both individual and population health change and the benefit is that most if not all people can identify with positive health outcomes (less cancer, longer life, safer communities, cleaner environment, etc.). In countries or communities with little understanding of the benefits of healthy behaviours, a little health promotion can go a long way to create spaces for dialogue and ultimately policy and behaviour change.

While some participants felt that change is reliant on the setting and conditions it operates with, others maintained that approaches require more active participation with long-term influence for the Charter to deliver its opportunities optimally. Lack of action and implementation, despite good intentions and ideas, was considered as untapped potential among some practitioners. Though the Charter sparks motivation and hope, particularly at its conferences, a Charter with misplaced action or disagreement upon its principles will simply remain a Charter. Though the progress s visible over the past 30 years, the unfulfilled potential coupled with emerging health threats may help to explain why 80% of participants in this study felt that the topic of Health Promotion is need of a deeper reflection since the development of the Ottawa Charter (*Figure 9*). Perhaps this challenge is best decribed by civil rights activist Rev. Dr. Bernard Lafayette from Emory University who, when addressing non-violent social change, stated: *"*It's one thing to be concerned by a problem, another to take action, and then a whole other thing to take the kind of action that has the potential to bring about changes and solve it" (Lafayette, 2017).

6.4 BARRIERS

The theme of Barriers also includes categories answering to the second research question "What progress and changes have occurred globally and within HP since the Charter was introduced?" Qualitative categories ranged from political, social and financial matters, exterior factors demanding greater attention, the dominance of a medical mindset and over-reliance on treatment, and delays in results which include lethargic dissemination of evidence, meeting of goals, and altering of behaviours.

Investment in Health Promotion has proven tricky, as demonstrating the efficacy of Health Promotion has its complications, given that many efforts are long-term or in process. Saan and Wise (2011) assert that "even within the health sector, it has been difficult to achieve and sustain national and local commitment to public health and health promotion and to build their budget" (Saan & Wise, 2011). However, the challenge remains to advocate that health is something worth investing in with benefits for individual and populations as a resource for daily living and thriving societies, yet not reducing it to costs avoided (Saan & Wise, 2011), or a "service" mentality focused on inputs and outcomes (Ziglio et al.,2000). At the same time, clear guidelines and objectives are required for such an investment.

Though the Charter maintains that "all sectors have roles in promoting health and health quity" (Saan & Wise, 2011), this has been challenging to operationalize. Various sectors have individual agendas and interests whose priorities may not be focused on what fosters or harms the conditions necessary for preserving and promoting good health, or are influenced by corporate interests. Political willingness may not be under enough pressure to move from authoratative governance requiring compliance to those in power versus commiting to a democratic and mutually dependent system involving the voices and participation of it's citizens. Though a lofty ideal, the conflict of interest will continue to threaten the public's health as "people cannot achieve their fullest health potential unless they are able to take control of those things which determine their health"(Saan & Wise, 2011). The issues of investment, political will, competing interests, intersectionality, and social barriers are delicately interwoven.

Lack of investment and lack of immediate outcomes and evidence are also closely related. "There is an increasing imperative for health services to demonstrate their clinical and cost-effectiveness" (Ziglio et al., 2011). It may be challenging to demonstrate the values of a health promoting intervention and its effectiveness as results are not immediate and globally applicable. Part of this demonstration requires "using the growing evidence about the economic gains from investing in prevention and promotion as well as the growing evidence about the costs of not acting to prevent ill health" (Ziglio et al., 2011). Though immediate outcomes may not always be a feasible goal, the broader application of evidence-based Health Promotion is necessary, yet considered to be lethargic (Johannson et al., 2010).

A generous portion of participants express their frustration around the perceived heavy concentration on treatment and cure in their region and when working with other professionals, stakeholders and citizens. "As long as no one demands access to Health Promotion efforts, curative care will be prioritized because needs are more obvious and require more immediate attention"(Johannson et al.,2010). This is in line with some of the opinions of participant in our study, who claim there are "there are other important issues." Prevention does not carry the same sense of urgency that curative treatment does and requires a shift of perspective where individuals often have to "see it to believe it" or wait until one becomes ill, experiences pain, or harm.

As data regarding non-communicable disease and other health threats continue to stream in, the time has come for prevention and treatment to work hand in hand with mutual respect.

In their study, Johannson et al. (2010) found that among other health professionals in primary care and hospital settings, "physicians felt least skilled in dealing with HP and prevention issues" and that "physicians had the least positive attitudes towards Health promotion in health service" (Johannson et al., 2010). Instead of cursing the darkness, it is important to understand the factors behind this to steer such perspectives in a health promoting direction. Johannson et al. (2010) quoted Pels, Bor & Lawrence (1989) who explained that "physicians are by nature and training problem solvers influenced by the diagnostic and therapeutic intervention made possible by advances of biomedical science" (Pels, Bor, & Lawrence, 1989). Curative perspectives then should not be seen as something to be fixed, but shaped by proper advocacy as well as adequate support such as "more skills in Health Promotion interventions, lifestyle counseling, empowering communication" (Johannson et al., 2010).

Disease-oriented perspectives have also been a concern, partly as a consequence of the growing disease burden. As Ziglio et al. (2011) state: "there is a real risk that with health budgets coming under pressure and with the burden of non-communicable diseases, that health promotion and preventive efforts will focus merely on lifestyle change and individual responsibility." Ziglio et al. (2011) explain that though depending on individual behaviour change is often not appropriate for those experiencing challenging and inequitable conditions, it is frequently relied on as it is simpler or quicker than undertaking political measures to improve the social and economic conditions that threaten the health of populations (Ziglio et al., 2011). At some level however, shaping attitudes and behaviours is inevitable in the process of health promoting initiatives yet attention should be paid to over-reliance on such approaches especially where determinants are overlooked or ignored as a result.

6.5 PRACTICE

The theme of Practice clarified the third research question which investigated "How have the Charter and Health Promotion concepts and principles been applied?" The content within the qualitative categories addressed how Health Promotion connects with other disciplines, how it distinguishes itself from other fields, as well as the unmet opportunities and areas for growth. Perceived use of the Ottawa Charter Action Areas was also organized into the theme of Practice and analyzed in more detail.

Regarding the perceived use of Action Areas in the Health Promotion and Public Health field, Developing personal skills and knowledge (63.7%) was rated most frequently and regularly used in one's country among participants, highest among Western (74.5%) and Northern Europeans (71.1%) and lowest for Eastern (52.6%) and Southern Europeans at 50%, with no significant difference between geographic regions. It was also perceived as more commonly used with researchers and educators (66.3%) and HP and public health

practitioners (64.3%) than for curative/palliative care workers (47.4%). Among professions, one possibility is that educators and researchers are focused on building on and disseminating knowledge and the HP and public health practitioners may also be more aware of the available resources and programs and directly involved in implementing them. With regard to curative/palliative workers, systematic and occupational factors may be at play such as "heavy workload, lack of guidelines, and unclear objectives" (Johannson et al., 2011). Johannson et al. (2011) determined that in clinical and hospital settings "evidence based HP and disease prevention methods and strategies need to be applied more widely." Furthermore, in their study, health professionals who felt least equipped and willing to handle HP and prevention matters were more curatively oriented such as physicians, midwives, nurses and hospital personnel vs psychologists, occupational therapists and primary health care personnel (Johannson et al., 2011).

Though sharing health information and education has shown to be an area with a fair amount of use in all geographic regions, The Vienna declaration (2016) describes the current challenge is now the overload of information as well as misinformation that is now quickly accessed by citizens (EUPHA, 2016). Managing this will require creative strategies from health promoters and the public health community as well as gaining the trust and respect of the public to continue sharing and disseminating credible knowledge and skills. According to participants, health promoters and public health practitioners should also be mindful of ensuring their research reaches the public outside of the field.

Developing healthy public policy was declared as used by 44.3% of respondents, highest among Northern Europeans (53.3%) and lowest among Western Europeans (36.2%), with no significant difference between professional domains. Over the past thirty years, more attention has been given to social, commercial and political determinants of health and their hidden influences which has allowed for the development of methods to highlight inequities and threats to health (EUPHA, 2016). There have been good examples of policies that aim at risk factors and disease reduction, though "comprehensive national policy that integrates actions to improve health and social and economic conditions across sectors is seen more rarely" (IUHPE & CCHPR, 2007).

Even though more attention has been given to this domain in recent years (Kickbusch, 2010) and stakeholders interested in health are increasing, there was concern voiced among our study's participants that training in health promotion requires better knowledge of political science/systems, in order to effectively advocate and mediate on a political platform. Furthermore, when research and services get streamlined into other levels of government to achieve health in all policies, there is a risk of such efforts no longer being recognized under the Health Promotion umbrella. Though the burden does not fully rely on Health Promotion, as a result, health promoting initiatives may be categorized under education, environment, housing, nutrition and not necessarily Health Promotion. At the same time, "to act effectively on the determinants of health, all sectors including healthcare, education, environment, transport, housing, and

commerce must take responsibility for promoting health (IUHPE & CCHPR, 2007)." This is a delicate dance while the field requires accountability and value to progress, but must share the responsibilities and successes with others.

Among our study participants, challenges in fully realizing the potential of this domain have been related to conflict of interest and lack of intersectionality, lack of value, lack of resources and investment, curative and disease oriented perspectives, and professional issues to name a few. Progress in the political realm also requires extracting elements from best practices and successful models to prove efficacy. As stated by the IUHPE and CCHPR (2007):

> Without the means to deliver its goals, healthy public policy is little more than rhetoric. It is imperative that we draw on existing models of effective health promotion policy at national and local levels to demonstrate its contribution across the span of the policy agenda from action on individual lifestyles to social and economic determinants.

Strengthening community action

According to the sample in this study, 41.1% of participants rated this action area as used, perceived highest for Northern Europeans (53.3%) and least for Eastern Europeans (10.5%) and perceived as used highest among curative/palliative/prevention workers (47.4%) with 38.6% of health promotion and public health practitioners and administrators on the lower end**.**

The struggle in using this domain can be in part due to its complexity, which may focus on a different purpose or require engagement in various stages at different times such as participation, or becoming "concerned with building on competencies and capacities and is directed at specific goals and actions." At another stage, strengthening community action may be assisting communities to solve issues related to their lack of power and locating or using their voice to be more politically active. This has been considered to be the catalyst for "empowerment" (Laverack & Mohammadi, 2011), a term which though explored in this domain, is often elusive with its absence of concrete methodologies and strong evidence in diverse settings and cultural environments (Laverack & Wallerstein, 2001). Whether it is viewed as a process or an outcome and how it is measured is also complex (Laverack & Wallerstein, 2001). This in turn influences funding and support for health promotion programs focused on strengthening community action and making community empowerment an operational concept (Laverack & Wallerstein, 2001).

Furthermore, it is possible that its reliance on reorientation of health services and professional practice (Laverack & Mohammadi, 2011) as well as the political climate that influences practitioners, communities, approaches and agendas (Laverack & Mohammadi, 2011) can further complicate the use and feasibility of this action area. According to sentiments in some of our study's participants, health promoting programs

should be keep in mind that highlighting the perspectives and strengths of participants they are targeting is required for this action area in order to "do with" instead of "doing for." Furthermore, "health promotion programmes are most successful when linked to the normal daily life of communities, building on local traditions and led by community members" (IUHPE & CCHPR, 2007). Future planning in this action area should consider this and act accordingly. Online platforms and networks should also now be considered as "communities" that encounter health hazards and adequate support and communication should be available to promote empowerment for this audience. As IUHPE and CCHPR (2007) state*:* "we must work hand in hand with communities and civil society, and ensure that our communications are accessible to all and understood by all."

Creating supportive environments

36.3% of survey participants perceived Creating supportive environments to be used, 48.9% among Northern Europeans, followed by Western (38.3%) and Southern Europeans (28.3%) and 10.5% among Eastern Europeans, perceived to be used mostly by researchers and educators (41.6%).

According to the IUHPE and CCHPR (2007), settings-based initiatives should be cultivated as health promoting workplaces and schools tackle health determinants and behaviours. Furthermore, in Europe and beyond, "since the Ottawa Charter a plethora of international and national programmes and networks have emerged, covering settings as diverse as regions, districts, cities, islands, schools, hospitals, workplaces, prisons, universities and marketplaces" (Dooris, 2006). Though a big progress, the influence is not as strong as could have been and concerns exist whether a consequence of a settings approach may at times result in fragmentation as settings operate at different levels (Dooris, 2006).

Furthermore, since the Ottawa Charter has been developed, the unfortunate deterioration of living and working environments has become a reality for many with new employment models, deindustrialization and reckless development threatening workers, families, neighborhoods, communities as well as social and physical settings (EUPHA, 2016). Moving forward, existing and new data that demonstrates the consequences on health and wellbeing is to be used more effectively (EUPHA, 2016).

Reorientation of health services

While 30.5% of survey respondents felt this action area was used, 10% perceived it to never be used at all. A similar percentage of Northern (35.6%) and Western Europeans (34%) declared its use, while the rate dropped for Southern (25.9%) and Eastern Europeans (21.1%). Researchers and educators (32.7%) along with health promotion and public health practitioners (30%) declared its use more than curative/palliative/prevention workers (21.1%). This is not surprising as moving Health Promotion to the mainstream requires the investment, value and collaboration of various stakeholders at local, regional and

global levels (Ziglio et al. 2011) and according to participants in our study, has been difficult to achieve. Wise and Nutbeam (2007) assert that this action area has had minimal systematic attention as its own action area and with respect to the four other action areas and is "still an unaccomplished agenda." Ziglio et al. (2011) explain that part of this is requires greater attention to the reframing of health promotion's main messages.

Johannsen et al. (2010) observed that though there may be a willingness among health professionals in their Swedish sample to engage in more health promotion and disease prevention in primary care and hospital settings for example, heavy workload (70%), lack of guidelines (47%) unclear objectives (40%) and low priority from management (31%) are some barriers that have made this challenging, with physicians reporting limited health promotion competency (44%). Within our own study, struggles in working with other health disciplines and sectors was also identified as a barrier. Yet the recent Vienna Declaration points out that engagement with health care professionals is essential for the public health community and requires cooperative action and sharing of resources in health systems so priorities are effectively addressed and preventive measures are delivered accordingly among health disciplines (EUPHA, 2016).

With the exception of Developing Personal Skills, the perceived use of action areas in one's geographical region was in the order of Northern Europe, Western Europe, Southern Europe and Eastern Europe, with Community Action and Supportive Environments being particularly low for Eastern Europeans. Though no conclusions can be drawn in this descriptive study, this pattern may give insight to the state of Health Promotion and Public Health progress and practice in these regions. Responses from a survey observing differences in public health research between Northern, Southern and Eastern Europe indicated that health services, health promotion, prevention and education were priorities at a national level in countries identified as Northern and Western Europe in our study (Mannoci, Ricciardi & La Torre, 2009). Infrastructures and technology shortages were identified barriers in Southern and Eastern Europe compared to the North, with their national priorities including health services and cardiovascular diseases, food safety and nutrition, environmental and occupational health (Mannoci et al., 2009).

Though the action areas are being looked at individually in our study, one must keep in mind that they are designed to interconnect, which may impact their separate and overall use. However, as Ziglio et al. (2000) point out, "most health promotion activity has continued to be issue based or else has focused on only one determinant at a time." Therefore, health promoters should also be conscious to design interventions to actively target more than one action area at a time, recognizing and demonstrating that each domain is mutually dependent on another. Otherwise, there may be a risk of "oversimplified approaches" which may only result on "small-scale and minor adjustments, and without any major impact on the determinants of health or policy development (Ziglio et al., 2000).

The final categories relevant to the theme of Practice in Health Promotion included various factors around professional concerns and potential, possibility for connection and collaboration with other disciplines and sectors, and the need for visibility and a voice. Though Health Promotion was positively viewed as compatible with various other fields, an opportunity to expand and for more collaboration with other health services and professionals exists. Sparks (2010) notes that:

> Health promotion as a field- and health practitioners as a body- are often discussed as if they are a homogenous group, all concertedly working toward the same set of goals. In reality, health promotion is made up of grassroots practitioners, researchers, teacher, community educators, project workers, policy makers, social movements, Non-Governmental Organizations (NGOSs), governments, advocates and others. Some practitioners and groups move comfortable among multiple roles in this list, while others are steadfastly devoted to only one.

Perhaps an important point when considering expansion and collaboration is best captured by the IUHPE and CCHPR (2007) who argue that "appropriate alliances are needed with professionals and academics from related fields that share the common goal of promoting health, while acknowledging that health promotion is a distinct field and body of knowledge in its own right." This has also called for more Health Promotion education and competency building in its own academic programs and in training programs of health professionals (Johannson, 2011; IUHPE & CCHPR, 2007) where "transnational agreement on health promotion core competencies is needed to further define the field and provide common direction for curriculum development (IUHPE & CCHPR, 2007).

Professional gaps were expressed and also evident with the perceived use of action areas, which is also expressed in the literature. Dooris (2006) argues about the lack of Health Promotion in most countries and IUHPE and CCHPR (2007) state that "workforce capacity and capability for Health Promotion is well developed in only a few countries, and under resourced or entirely lacking in many." Perhaps this is further complicated by the fact that "the composition of health promotion as a field is further complicated by the greatly varying levels of capacity, funding, infrastructure and other pre-requisites for promoting health both within and between different parts of the world." (Sparks, 2010).

Shifting focus towards stronger and more visible advocacy in the face of injustice and inequality is suggested among survey participants, as well as the reframing of key Health Promotion messages, particularly among other disciplines. Ziglio et al. (2011) suggest that "broadening our dialogues to better engage colleagues within the health system" is necessary and Health Promotion skills should be part of the professional development of everyone working in health services" (Ziglio et al., 2011).

6.6 IMPACT

The theme of impact includes categories answering to the fourth research question "Is the Charter known and still relevant in today's context and where does Health Promotion stand?" which included survey results on perceived value and recognition of Health Promotion (Figure 17). Qualitative data revealed responses ranging from the positive impacts and benefits on people, systems and creative solutions to the need for greater value and awareness.

A little over 70% of participants felt that Health Promotion sparks interest and engagement for those within the public health field, while a much lesser amount (40%) felt that it is known, understood and valued outside of the field. This makes sense as professionals are naturally more involved with what is going on within their field than the general public. However, the question of value runs deeper. Johannson et al. (2010) determined that "if the goal of more health promotion in health services is compatible with the health professional's own values, norms, perceived needs, the process of successful implementation will increase." This demonstrates how such integration is vital and connected to the perceived value of health promotion, which will vary among professionals and individuals and factors shaping their roles and attitudes.

Increased value for Health Promotion among stakeholders and the public is necessary to increase its demand. Without demand, "HP will be something that occurs infrequently, and something extra added if health professionals have time (Johannson et al., 2010). Though debatable, part of this does include framing Health Promotion as an essential service, not just a hopeful concept. "A service with clear overall goals and tangible milestones increases the possibility of a shared vision of mission and this in turn facilitates prioritization" (Johannson et al., 2010).

Still, some of the study participants have indicated that the impact has been constructive associating Health Promotion with addressing root causes and preventing them, its ability to positively influence citizens, tackling injustice, and its effect on many levels. Over 70% of respondents feel that HP is a necessary field. Considering the population in the survey contributes to the public health community in some way, this indicates that lack of awareness or value is not exclusive to the public, but even within our own field there is room for proving its worth, a gap where Health Promotion has yet to make a greater impact than what the Charter promises.

6.7 LIMITATIONS

The self-selection of individuals surveyed is a large limitation to this study as they were only a small portion of health promotion and public health practitioners invited to participate and that contributed to the study. Out of 2400 EUPHA Health Promotion section members, the final study population was 193 respondents.

Though section membership includes both active and passive members, this is a strong limitation when interpreted in light of ideal response rates and includes mostly European perspectives.

Self-reports such as surveys are at risk for response bias, which can affect the validity of the study. Phrasing of the questions and responses elicited by such phrasing should all be kept into consideration. Participants and researchers were already somehow connected due to their involvement in the field that was being analyzed, which also limits the diversity of the results.

Furthermore, though this study indicates its focus on the European region and surveyed professionals connected to EUPHA, voices and perspectives of both developing and developed regions outside of Europe are not captured. Therefore, it excludes valuable perspectives of how useful or relevant the Charter has been outside of Europe. Furthermore, it excludes perspectives of those who are not yet experts or professionals, such as students or laypeople. In the spirit of democracy, future reflections on the Ottawa Charter should seek to explore perspectives of the Ottawa Charter and its relevance from professionals outside of Europe and in developing regions, as well as among non-experts. The Charter is a powerful document which should not only circulate and be analyzed within the public health community.

With regard to reflexivity, although the author reflected on positionality before the analysis to eliminate any possible bias, interpretation of the literature as well as qualitative text and it's classification into units, categories and themes may be intrinsically influenced by the background of the author. Such background includes having worked in a Canadian health care system and studying in a European system.

7 CONCLUSION

By exploring the essence of the Ottawa Charter and Health Promotion, global and professional progress and changes since its inception, the application of its concepts and practices, and questioning its relevance, it is clear that the perceived significance of the document exists, but it's application requires work. Clarification of the concept and concrete delivery of the Charter's main messages, distinction of the profession and discernment of its priorities and partners, sound coordination when naming and addressing barriers and challenges, and regular recording and review of its progress and impact are factors that have emerged as requiring attention.

With regard to the question of the Charter's relevance and where Health Promotion stands, The Ottawa Charter can be viewed as a relevant concept as its vision highlights relevant issues that have yet to be resolved, and presents roles (enable, mediate, advocate) yet to be fulfilled and action areas yet to be optimally implemented. Thus, its relevance is highlighted in the fact that because of it much has been done, yet there is still much more left to do to fulfill its vision.

In order for the Charter to live up to its potential and its impact to continue to be realized, more accountability is required for its use. With the various occupational domains acting within Health Promotion as observed in this study and numerous geographic regions in Europe with diverse communities and localities, there is a risk of many independent Health Promotion projects posing increasingly fragmented results, evidence and dialogue resulting in small-scale impact and lack of awareness among the public and within the field. While different regions will have different priorities, at minimum, accountability should include criteria that connects with the principles of the Ottawa Charter and Health Promotion, or the current Vienna Declaration. Furthermore, making a case for Health Promotion should demonstrate how the roles of enabling, mediating and advocating will be interwoven, how the action areas will be used (more than one at a time if possible), highlighting the short-term impact on health and well-being, and ensuring it does not in any way exacerbate the current issues or create alternate issues for the population or community in question. Demonstrating how this issue connects to other imperative issues currently being explored and tackled in Health Promotion in developed and developing regions is vital to not only collaborate with other health promoters, but to connect the small-scale efforts so that they have a large-scale impact in alignment with the Charter's vision.

Creating a strong community of health promoters both in training and practice will not only aid in more clearly defined roles, tasks and goals, it will create a stronger and unified voice and presence necessary for advocacy on various political platforms and for a credible and engaging online and public platform, both which require the convincing of an often skeptical and preoccupied audience. Strengthening the profession and making it more distinct can create the possibility to work together towards mainstreaming Health Promotion into other fields and professional roles, so that Health Promotion action can manifest itself beyond its concepts and principles. This does not mean Health Promotion should solely bear the responsibility of prevention, but it must be distinct enough to teach what we know, show and lead the way.

Leading will take different shape and form according to the Health Promoter's own principles, goals and roles. Therefore educating, whether it is other professionals or community members, needs to be an empowering process, not simply a manner of telling. Respecting goals as defined by others, their roles, or their culture, may not always meet the expectations and outcomes of the health promoter, but it would fulfill their needs or contribute to community empowerment or developing personal knowledge and skills for example. Such openness is necessary to set an example for those who attempt to control populations instead of guiding or enabling them.

7.1 FUTURE RECOMMENDATIONS

The Ottawa Charter presents principles that challenge self-centered interests and conformity to inequitable and harmful circumstances threatening population health and well-being. Improving structural, cultural and other determinants requires constant and tireless pressure and advocacy to protect the most vulnerable and voiceless in society, and now is certainly not the right time to give that up.

However, as some participants in our study reflect, the reality has not fully satisfied the vision that the Charter vows, often resulting in good and well-meaning intention, but lack of or misplaced action. As a method and theory, it shows great potential for positive change, but when standing alone, has limited influence on larger scale improvements requiring greater attention to organizational and professional measures. Various opinions and suggestions are demonstrated within the literature as well as among the professionals participating in our study which should be addressed. Documents such as The IUHPE and CCHPR's Priorities for Action (2007) has addressed gaps and summarized respectable guidance around them with areas of focus while The Vienna Declaration (2016) comes at the right time to shift the dialogue and perspective as it updates and extends the prerequisites for health as outlined in the original Charter. By combining these perspectives, it is now necessary to unite on Health Promotion concepts, principles and vision, so our messages are clear to all and action is driven by key messages with concrete examples for application. Though the content of the Charter is relevant, specific demonstration and recording of how the action areas have been used is needed to help determine how to effectively use them in various settings among diverse professionals. Examples of how they have been unsuccessfully implemented and have not reached their intentions in specific regions or among various domains is just as important in order to avoid repeating the same mistakes or misguided efforts.

Though the messages of the Charter are relevant, it requires a loud voice, constant repetition, and an organized action plan and platform. Some suggestions that may help support this are:

1. Unite main messages of Health Promotion from documents, literature and professional perspectives to move forward with a sound, clear concept. Those working within Health Promotion should become skilled at highlighting and clarifying these messages in a way that influences greater recognition and appreciation for its objectives.
2. Focus on research and recording systems that exhibit the successful and unsuccessful implementation of Ottawa Charter principles, roles, and action areas in both developed and developing settings. These should be easy to manage and access and give better understanding of "how to" do health promotion in order to develop relevant implementation instruments and tools to best guide and advise professionals and target groups.

3. Connect current health information and knowledge so that is easily accessible and understandable to the public and human service professionals. Connecting separate bits of information such as tackling similar risk factors for various diseases at once and development of skills transferable to several positive health behaviours at once. This prevents risk of fragmentation of information which may get lost in many individual projects. Use of infographics, podcasts in various languages may help articulate the main points in a quick and comprehensive manner. Practical facts on how to do (shop for, prepare, cook healthy food, interpret labels) versus nutrition facts or statistics will better support empowerment and resilience in the face of unhealthy choices and environments.
4. Create a stronger online presence to deliver accurate health information where distorted or commercial messages dominate and are easily accessed.
5. Sharpen the professional practice for health promoters with clearly defined roles and standards for practice while expanding their involvement with other health professionals working towards similar goals. This requires competencies related to communicating, negotiating, group dynamics, as well as a mutual respect for, understanding of and working with other disciplines, including those with dominant clinical and disease-oriented perspectives. These should be continually and practically reinforced in academic and professional training as well as upcoming literature.
6. Skills to advocate on a political level and with the media are needed not only to attract greater attention and resources, but to reveal injustice, tackle barriers and health threats, and expand our dialogue.
7. Continue to tackle environments that fail to support our health and collaborating with other disciplines as needed to examine the internal and external determinants and behaviours that threaten, and providing the skills and resources to address them and manage them where long-term changes are not immediately possible.
8. Work alongside individuals and communities to create solutions with them and not for them, sensitive to their traditions, beliefs, and models of health and wellness. Draw upon other models of health and incorporate these when disseminating data and implementing action plans.
9. Develop greater capacity to strengthen international action in addition to national and local action.
10. Constant dialogue among professionals in addition to conferences and incorporation of professional perspectives from developing and developed regions. Many suggestions for improvements from professionals which could not be addressed in this survey have been expressed which may assist the EUPHA Health Promotion section for future action.

7.2 LAUNCHING THE VISION INTO SYSTEMATIC ACTION

The results suggest that the Ottawa Charter is in need of a greater reflection. However, it is also true that a greater reflection is needed for the Ottawa Charter to be properly integrated and applied so it is better used and valued in the field of Health Promotion and beyond. By exploring and solidifying aspects in need of reflection within the core themes of Concept, Potential, Barriers, Practice and Impact, it is possible that Health Promotion can move forward by embracing its original spirit of the Charter, but addresses the issues that need immediate prioritization and care. Doing this well undoubtedly relies on a holistic, positive and protective vision and concept, but should not underestimate the need for practical tools, examples, direction and coordination on professional and organizational levels.

Results also show that whether perceived as relevant or not, it needs to be viewed as a process that takes time and not solely a service or outcome, which makes proving its worth more complex. However, getting stuck in a purely idealistic concept or delayed process will also be counteractive. Furthermore, The Ottawa Charter will manifest itself differently depending on its context- as an ideal, concept, professional practice, geographic region, national or local level, and professional domains and players involved. However though greater reflection is necessary, its continued relevance can be viewed through its impact over the past 30 years, the potential that has yet to be fulfilled but shows promise, and the barriers that have yet to be overcome.

The Ottawa Charter has potential to give vision to addressing today's challenges, as such a vision works to identify and expose determinants and conditions working against health in need of remediation. This is an important role in times when silence or denial feed dysfunctional systems that need disruption, and to stand against injustice in order to grow towards empowerment and thriving of human populations. The vision keeps us connected with what is broken in the world and what pieces are needed to restore it. The task is now to place the vision into practical, coordinated action that changes the conditions and systematically solves the problem.

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III DECLARATION OF INDEPENDENT WORK

I hereby declare that I wrote this thesis without any assistance and used only the aids listed. Any material taken from other works, either a quote or idea have been indicated under ‘References’.

_____ _____

Angelika Milczarski (Wilberg) Place, Date

IV APPENDIX

Personal definition of Health Promotion	F
Individual and community empowerment	19
WHO/Ottawa's definition	18
Supporting and creating healthy lifestyles	15
Health education, knowledge and skills	15
Supportive environments	12
Health maintenance and improvement	12
Overcoming health threats, barriers and root causes	10
Improving structures, systems and determinants	10
Positive health, wellbeing and quality of life	8
Prevention of diseases	6
Shared responsibiliy for health	4
Difficult to define	3
Total	**131**

Figure 25: Personal Definition of Health Promotion - Ottawa Charter and Health Promotion Cross Sectional Survey 2016

Perceived use of action areas in reference country	Used very often	Used regularly	Sometimes used	Never used	Unsure
Developing healthy public policy	16.7%	27.6%	47.4%	7.3%	1.0%
Creating supportive environments	10.5%	26.8%	58.4%	2.6%	1.6%
Strengthening community action	11.6%	29.5%	53.7%	4.7%	0.5%
Developing personal skills and knowledge	32.6%	31.1%	33.2%	1.6%	1.6%
Reorientation of health services	8.9%	21.6%	56.8%	10.0%	12.6%

Figure 26: Perceived use of action areas in reference country- Ottawa Charter and Health Promotion Cross Sectional Survey 2016

Perceived reasons influencing Health Promotion's recognition among health professionals, researchers and policy makers	**F**
Increasing health interest and concern	14
Holistic and positive vision	10
Complementary to other roles, fields and sectors	7
Multi-level impact	5
Progress of HP presence and importance	4
Total	**40**
Perceived reasons influencing Health Promotion's lack of recognition among health professionals, researchers and policy makers	
Intention but lack of action	16
Curative/disease oriented perspectives	11
Unclear concept	10
Conflict of interest and lack of intersectionality	10
Lack of political will and investment	8
Lack of immediate outcomes and evidence	7
Lack of awareness and appreciation	6
Professional progress required	4
Total	**72**
Total responses	**112**

Figure 27: Perceived reasons influencing Health Promotion's recognition among health professionals, researchers and policy makers- Ottawa Charter and Health Promotion Cross Sectional Survey 2016

Perceived reasons influencing Health Promotion's recognition among the public	**F**
Health conscious citizens and stakeholders	11
Effective intersectoral collaboration	10
Increasing awareness and impact	8
Setting and field dependent	3
Total	**32**
Perceived reasons influencing Health Promotion's lack of recognition among the public	
Unclear concept	20
Low awareness	14
Curative/disease oriented perspectives	12
Lack of political will and intersectionality	10
Lack of immediate outcomes and evidence	8
Lack of value	7
Behaviour change	5
Professional progress required	3
Total	**79**
Total responses	**111**

Figure 28: Perceived reasons influencing Health Promotion's recognition among the public - Ottawa Charter and Health Promotion Cross Sectional Survey 2016

Perceived strengths and opportunities for Health Promotion	**F**
Positive vision and values	18
Individual and community potential	17
Promotes social responsibility for health	16
Health and social benefits	15
Provides opportunity for expansion and collaboration	12
Asset based and sustainable principles	12
Addresses root causes and prevention	11
Tackles inequalities and health threats	9
Professional potential	6
Improved settings and systems	6
Total	**122**

Figure 29: Perceived strengths and opportunities for Health Promotion- Ottawa Charter and Health Promotion Cross Sectional Survey 2016

Perceived challenges for Health Promotion	**F**
Professional concerns	16
Sustainable and participatory approach needed	11
Political and social barriers	11
Reaching and impacting people	10
Shift of focus required	9
Competing issues and interests	6
Advocacy and visibility	6
Total	**69**

Figure 30: Perceived challenges for Health Promotion- Ottawa Charter and Health Promotion Cross Sectional Survey 2016

Your participation will make it clear... what is health promotion to you!

Please take a minute to help us improve what we do! We appreciate your feedback and collaboration. For more information please contact [redacted]).

Gender

get more information at www.saboga.net & follow us on-line

- ☐ male
- ☐ female

How old are you?

- ☐ less than 25
- ☐ 25-34
- ☐ 35-44
- ☐ 45-54
- ☐ 55-64
- ☐ 65 or older

How long have you been working in the field of health promotion/public health

- ☐ less than 5 years
- ☐ 5-15
- ☐ 16-30
- ☐ more than 30 years

What type of professional domain do you identify with?

- ☐ curative/palliative care worker
- ☐ prevention care worker
- ☐ health promotion
- ☐ researcher
- ☐ teaching/education
- ☐ public health practitioner or public health administration

☐ Other:

1. Please provide a country of reference for your work as a health professional.

Please share your opinion on how strongly you agree or disagree with the following statements where 1 is "agree", 2 is "slightly agree", 3 is "unsure", 4 is "slightly disagree" and 5 is "disagree":

2. Since the development of the Ottawa Charter in 1986, the field of health promotion is well established in my country.

	1	2	3	4	5	
I agree	○	○	○	○	○	I disagree

3. After 30 years of the Ottawa Charter, the field of health promotion is well established in Europe.

	1	2	3	4	5	
I agree	○	○	○	○	○	I disagree

4. Overall knowledge about the topic of health promotion has progressed over the past 30 years.

	1	2	3	4	5	
I agree	○	○	○	○	○	I disagree

5. The topic of health promotion is in need of a deeper reflection since the development of the Ottawa Charter.

	1	2	3	4	5	
I agree	○	○	○	○	○	I disagree

6. In my perspective, the following health promotion strategies are widely used/applied in health promotion practice in my country:

	Never used	Sometimes used	Used regularly	Used very often	I do not know
Developing healthy public policy/Health in All Policies	○	○	○	○	○
Creating supportive environments	○	○	○	○	○
Strengthening community action	○	○	○	○	○
Developing personal skills and knowledge	○	○	○	○	○
Re-orientation of health services	○	○	○	○	○

7. Is health promotion a topic that stimulates interest and engagement for health professionals, researchers and policymakers?

○ Yes
○ No

Please indicate why/why not:

8. Is health promotion a topic that is known, understood and valued outside of the Public Health Field?

○ Yes
○ No

Please indicate why/why not:

9 How do you personally define health promotion?

you can answer preferably in English or in your mother tongue

10. Do you feel that health promotion is a necessary field?

- Yes
- No

If “Yes”, please indicate some strengths and opportunities for health promotion:

If “No”, please indicate some weaknesses and threats for health promotion:

11. Please enter any details / activities related to health promotion you are involved in (programme / course / research).

12.a. Are you a member of EUPHA?

- Yes
- No

12.b. Are you a member of EUPHA Health Promotion section?

- Yes
- No

12.c. If you answered "no" to the previous question would you like to be more involved in the Health Promotion Section?

- Yes
- No

13. We value your comments: As a health promoter, what do you enjoy and what do you find challenging? Do you have any suggestions or comments for the EUPHA section of health promotion? Thank you!

E-mail