Editorial

Health protection and promotion

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Evolution of health promotion: a stand-alone concept or building on primary health care?

The origin and evolution of health promotion is complex, and no single driver is responsible [*1*]. The predominant belief (and understanding) revolves mostly around the fact that health promotion as a public health component was introduced in 1986 by the World Health Organization (WHO) in Ottawa [*2*], paving the way for the subsequent health promotion movement. However, health promotion, as a conceptual framework, stimulating a shift in thinking began around 1978 when "primary health care" was adopted at the Alma-Ata conference as the principal mechanism for health care delivery [*3*]. The Alma-Ata Declaration underlined the WHO strategy of "Health for all by the year 2000" (1977) [*4*]. It crucially recognized that health improvements would not occur just by developing more health services or by imposing public health solutions and heralded a shift in power from the providers of health services to the consumers of those services and the wider community [*1*]. The primary health care initiative became the driving force for comprehensive health development over the following 2 decades, and provided the right environment for the concept of health promotion to develop and grow.

During the early 1980s, the term "health promotion" was increasingly used by a new wave of public health activists who were dissatisfied with the rather traditional and top-down approaches of "health education" and "disease prevention" [*1*]. This, however, generated a debate among the global public health community about the various theories and concepts of prevention, education and promotion. Whereas the term "health protection" existed long before that, and was considered to be consistent with the disease perspective and focused attention on prevention of disease risk factors and diseases [*5*], it has since been reinforced through the primary health care and health promotion approaches.

The debate prompted WHO to call a special meeting in late 1984 in Copenhagen to provide some clarity and direction. This led to the first substantive document on health promotion [*6*]. Two years later the first conference on "health promotion" in Ottawa defined the term as "the process of enabling people to increase control over, and to improve, their health" in the Ottawa Charter, which is still considered the most valid principle of furthering health promotion in the 21st century [*2*]. The definition has its roots in earlier initiatives such as the Alma-Ata Declaration, which introduced political action, social understanding, and economic policy to the concept of health promotion [*3*]. The Ottawa Charter further legitimized health promotion as it emphasized the need for intersectoral collaboration and equity in health [*2*]. The call for action for health

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promotion referred to 5 strategies: building healthy policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services. The Ottawa conference is often regarded as a milestone in the field of health promotion because a vision and a strategy to advocate health promotion were developed and effectively brought to the attention of the public.

In the ensuing 2 decades, the key achievement of Ottawa 1986 was to legitimize the vision of health promotion by clarifying the key concepts, highlighting the conditions and resources required for health, and identifying key actions and basic strategies to pursue the WHO policy of "health for all". Importantly, the Charter that emerged also identified the prerequisites for health, including peace, a stable ecosystem, social justice and equity, and resources such as education, food and income. It highlighted the role of organizations, systems and communities as well as individual behaviours and capacities, in creating choices and opportunities for better health [*1*].

Since the first conference in Ottawa, WHO has been instrumental in organizing subsequent global conferences on health promotion in partnership with national governments and associations. These mostly focused on each of Ottawa's 5 health promotion strategies. The Second International Conference on Health Promotion in Adelaide, Australia in 1988 explored in greater depth "building healthy policy". The focus of the Third International Conference on Health Promotion in Sundsvall, Sweden, in 1991 was on "creating supportive environments". This particular conference was the first where the notion was put across how environments (physical, social, economic, or political) can be made more supportive of health. The Fourth International Conference on Health Promotion held in Jakarta, Indonesia, in 1997 reviewed the impact of the Ottawa Charter and engaged new players to meet global challenges. The evidence presented showed that health promotion strategies can contribute to improvement in health and the prevention of diseases in developing and developed countries alike. Five priorities were identified in the Jakarta Declaration on Health Promotion into the 21st Century: promote social responsibility for health, increase investments for health development, consolidate and expand partnerships for health, increase community capacity and empower the individual and secure an infrastructure for health promotion. These were confirmed in May 1998 through the World Health Assembly Resolution on Health Promotion (WHA 51.12).

Despite the evolution of health promotion over the decades and the progress being made through these successive conferences as well as through the parallel initiatives WHO was taking, 2 important challenges remained. The first was to demonstrate, and communicate more widely to developing countries, that health promotion policies and practices can make a difference to health and quality of life. The second was even more important: that action for health promotion can achieve greater equity in health and can close the health gap between population groups [*1*]. That is why the Fifth Global Conference on Health Promotion in Mexico in 2000 primarily focused on health inequalities both within and between countries. This conference resulted in the *Mexico Ministerial Statement for the Promotion of Health: from ideas to action*, which affirmed the contribution of health promotion strategies in sustaining local, national and international actions in health [*7*].

At the dawn of the new millennium, it was increasingly realized that the global public health landscape was changing dramatically and that more understanding (and action) was required to address the determinants of health if the health of the population was to be promoted. Unforeseen opportunities and chal-

lenges surfaced, such as the negative effects of climate change on population, geopolitical changes, debt in developing countries, and of course globalization of people, money, products and services [*1*], which had very important implications on wider public health as well as the way health promotion should position itself.

It was in this context that the Sixth Global Conference on Health Promotion in Bangkok in 2005 identified actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion [*8*]. The conference was structured around 4 themes: the new context, health-friendly globalization, partners, and sustainability, and resulted in the second health promotion charter, which identified 4 key commitments to promote health (central to the global development agenda; a core responsibility for the whole of the government; a key focus of communities and civil society; and a requirement for good corporate practice) and 5 key action areas (advocate for health based on human rights and solidarity; invest in sustainable policies, actions and infrastructure to address the determinants of health; build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy; regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people; and partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions). The 4 key commitments and the 5 key action areas build on the previous key action areas put forward by the Ottawa Charter and articulate a renewed vision on health promotion, tackling the inequities and inequalities in health through addressing the determinants of health.

However, some of the terms commonly used in the public health community, e.g. disease prevention, health education, wellness, quality of life, and health promotion, have at times led to confusion in their understanding. It is therefore, important that the concepts of health promotion, prevention and protection are discussed so as to effectively understand the difference between these public health disciplines.

Prevention, promotion, protection and education in health: similar or different entities?

As mentioned above, a clear understanding of the terms (and their application) is essential for public health practitioners to understand:

- Are these more or less the same terms, and applied in a similar fashion?
- If different, can they be applied together?
- If the same, why are different terms used in public health practice?

This paper does not aim to generate a theoretical debate on these questions but to try to argue (based on the published literature) for a more rational approach in the meaning and application of these terms.

Prevention

Prevention in health calls for action in advance, based on knowledge of natural history, in order to make it improbable that the disease will progress subsequently. Preventive actions are defined as interventions directed to averting the emergence of specific diseases and reducing their incidence and prevalence in populations. The discourse of prevention is based on modern epidemiological knowledge. It aims to control the transmission of infectious diseases and reduce the risk of degenerative diseases or

other specific ailments. Health prevention and education projects are structured by circulation of scientific knowledge and normative recommendations to change habits. To promote means "to further the development, progress, or establishment of (a thing); encourage, help forward, or support actively (a cause, process, etc.)" (New Shorter Oxford English Dictionary, Oxford University Press, 1997). Traditionally, health promotion is defined more broadly than prevention, since it relates to measures that "are not directed to a given disease or disorder, but serve to increase overall health and well-being" [*9*]. Promotion strategies emphasize changing people's living and working conditions, which underlie health problems, calling for an intersectoral approach [*10*].

Although this undeniably constitutes progress, this positive concept entailed a new problem at both the theoretical and practical levels. By considering health in its full sense, we are dealing with something as broad as the notion of life itself [*11*].

Promotion

Health promotion reaffirms considering not only how to avoid being sick, a negative concept, but also how to expand the potential for living, a positive view: "The main difference between health promotion and disease prevention is the premise of health promotion regarding health as a resource of everyday life" [*12*]. Without doubt, most people want life to include being able to move about freely, enjoying food, feeling good, remembering things, and having family and friends.

This is clearly beyond disease prevention, and illustrates the importance of considering the nature of health promotion [*11*].

There are other dimensions differentiating health promotion from disease prevention which are embedded in the definition of health itself (WHO 1986): health balance and health potential [*2*]. Health balance is essentially the Hippocratic notion of dynamic equilibrium between the human organism and its environment, a basically stable relationship of a person with the world outside. On the other hand health potential consists of reserves, an individual capacity to cope with environmental influences that jeopardizes health balance. This concept goes beyond the idea of immunity to harmful biological agents: it includes the ability to withstand the adverse effects of causes leading to ill-health, the loss of a loved one or myriad other injurious circumstances of daily life [*13–15*].

Health is a phenomenon of the individual just as disease is: each person has a certain degree of health that may be expressed as a place in a spectrum. From that perspective, promoting health must focus on enhancing people's capacities for living. This means shifting them toward the healthier end of the spectrum, just as prevention is aimed at avoiding the conditions that can push them toward the opposite end. Of course, many of the actions, e.g. obtaining adequate exercise and appropriate nutrition, aimed at health promotion also achieve specific disease prevention. When such measures are directed against a particular disease, such as cessation of smoking to minimize the risk of lung cancer, they may be regarded as disease prevention; when the same measures are aimed at improving health generally, for example, preserving optimum respiratory and cardiovascular systems, they may be regarded as health promotion [*16*].

Health promotion is seen as a human right (as laid down in the constitution of WHO). This is a positive concept emphasizing social and personal resources as well as physical capacities. The responsibility of health promotion actions extends far beyond

the health sector and health behaviour to well-being and quality of life. It is a humanistic approach having the human being and human rights in focus again. The individual becomes an active and participating subject. The role of professionals is to support and provide options, enabling people to make sound choices; to point out the key determinants of health; and to make people aware of them and able to use them [*17*].

Protection

Health protection offers equality of opportunity for people to enjoy the highest attainable level of health, and is achieved through the development and implementation of legislation, policies and programmes in the areas of environmental health protection and community care facilities. Health protection in the modern public health age focuses mainly on:

- preventing and controlling infectious diseases
- protecting against radiation, chemical and environmental hazards.

In summarizing these disciplines based on the recent public health discussion, the available literature shows that the health protection perspective means that the interventions limit the risk of disease. The efforts and interventions are population-based and passive. Health protection aims at reducing the likelihood that people will encounter environmental hazards or behave in unsafe or unhealthy ways. The interventions are aimed at preventing people from falling into sickness or illness by building protective mechanisms. The preventive perspective utilizes active interventions characterized by an empowering attitude where people are actively involved. The rationale is to reduce the negative effects and risks, thus maintaining the health of the public. The interventions are both population-directed (protective) and individual-based (preventive) [*18*].

Education

Health education has a long tradition in public health practice. Originally, it was a question of the professionals informing people of health risks and giving advice on how people should live healthy lives. Today it is based on a dialogue, involving people in their own lives and making their own decisions supported by public health knowledge. People are, in general, more actively involved than in the previous stages. The interventions are directed towards both individuals and groups and one of the key outcomes is improved health literacy [*19*].

Discussion

Distinctions between health protection, health promotion and disease prevention are discussed in the literature in many ways. Health protection and disease prevention are considered to be consistent with the disease perspective. The dominant approach to "health" in the literature is health promotion, which focuses attention on facilitating health to promote wholeness, integration and harmony [*5*]. It is based on health philosophy, and utilizes health protection as well as promotion strategies to promote the health of individuals, families and communities.

A clear-cut demarcation between these public health disciplines, however, would always be difficult to achieve. This difficulty arises partly in the way modern-day public health is defined. One issue is that public health defines itself as responsible for promoting health, while its practices are organized around disease concepts. Another is that these practices tend not to consider the distance between the concept of dis-

ease (a mental construct) and falling ill (an experience endured), at times substituting one for the other [*11*]. It is precisely here that the radical, and at the same time very small, difference between prevention and promotion in health stands out. It is radical because it entails far-reaching change in the way knowledge is interlinked and used in formulating and operationalizing health practices, and this can only truly occur by way of a transformed world view, as discussed above. It is very small because, just like those of prevention, the practices of promotion use scientific knowledge.

Health promotion projects also rely on the classic concepts (disease, transmission, risk) that guide the production of specific knowledge in health and whose rationality is the same as that of prevention discourse. This can lead to confusion and a lack of differentiation between the practices, mainly because the radical difference between prevention and promotion is not always clearly affirmed or exercised. The idea of promotion involves strengthening individual and collective capacity to deal with the multiplicity of factors that influence health. Promotion goes beyond applying techniques and norms. It is not enough to know how diseases function and to find mechanisms to control them: it has to do with strengthening health by building a capacity for choice, using knowledge to discern differences between events.

In comparison with other established fields such as medicine, psychology, or sociology, the field of health promotion has only recently evolved. Health promotion has its roots in many different disciplines. As the field has developed, more and more components have become incorporated. Many of these components existed beforehand in their own isolated and limited sphere of influence: health education in schools or primary health care settings; public health programmes such as immunizations or screenings; and occupational health measures aimed at preventing disease or accidents at the workplace. These activities involve education, prevention, protection and legislation, and all relate to the concepts of positive health, well-being and lifestyle [*20*]. The health promotion model developed by Downie, Fyfe and Tannahill demonstrates the wide range of possibilities for health promotion by incorporating prevention, health education and health protection in overlapping spheres [*21*]. According to this model, Prevention focuses on services such as immunization, cervical screening, hypertension case-finding, the use of nicotine-containing chewing gum to aid smoking cessation, etc; health education is aimed at influencing behaviour on positive health grounds and seeks to help individuals, groups or whole communities to develop positive health attributes which are central to the enhancement of true well-being; and health protection deals with regulations and policies such as the implementation of a workplace smoking policy in the interests of providing clean air, or the commitment of public funds to the provision of accessible leisure facilities in order to promote positive health.

Health promotion not only incorporates all the domains described above, but also the overlapping areas. Preventive health education includes educational efforts to influence lifestyle in the interests of preventing ill-health, as well as efforts to encourage the uptake of preventive services. Preventive health protection addresses policies and regulations of a preventive nature such as fluoridation of water supplies to prevent dental caries. Health education aimed at health protection involves raising awareness of, and securing support for, positive health protection measures in the public and in policy-makers [*20*]. All 3 dimensions

come together as health education, prevention and protection overlap in efforts to stimulate a social environment conducive to the success of preventive health protection measures, e.g. intensive lobbying for seatbelt legislation.

These categories, however, are not rigidly separate compartments in practice but are in reality often combined. For example, most health promotion measures are of a preventive nature and aimed at empowering individuals to adopt healthy lifestyles. Further, the discussion also underlines the necessity to include other disciplines such as psychology, sociology, public administration, business and economics, communications and politics. This indicates that health promotion comprises efforts to enhance positive health and prevent ill-health through the overlapping spheres of health education, prevention, and protection.

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To deal with some of the underlying determinants of health, a global framework for a health promotion strategy is needed. This is a responsibility of all government ministries at all levels, as well as communities and corporate and civil society.

Source: *Engaging for Health. Eleventh General Programme of Work 2006–2015. A Global Health Agenda*