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Health education and health promotion revisited

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Abstract

Thirty years ago, the World Health Organization (WHO) Ottawa Charter for Health Promotion created a paradigm shift in addressing major public health challenges. Traditional approaches to health education focused on personal health 'risks' and lifestyle choices were quickly overshadowed by the attention given to more comprehensive policy and environmental interventions. Since that time health education has evolved in content, media use and sophistication of communication to fulfil a wider range of purposes. The concept of health literacy has been useful in sustaining this change. As the tools for communication have been transformed by digital communication, and the marketplace for communication has become more crowded and complex, health education has continued to evolve to reflect these changes, enabling people to navigate competing sources of information and to engage meaningfully with social and economic determinants of health. Equitable access to quality health education and lifelong learning remain the cornerstones of modern health promotion.

Keywords

Health education, health literacy, health promotion, public health practice, theory

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In 1984, I published my first contribution to the *Health Education Journal* with John Catford in the form of a paper titled 'Towards a Definition of Health Education and Health Promotion' (Catford and Nutbeam, 1984). It was a paper of its time – a contribution to an evolving, sometimes passionate debate about the emerging concept of health promotion, and its relationship with established health education. It makes interesting historical reading, painting health education into a corner as a limited tool for raising awareness, changing attitudes and promoting 'voluntary changes in behaviour'. By contrast, health promotion was cool, new and exciting. As we described it at the time, it not only included health education but also an ambitious set of strategies that were intended to revitalise public health interventions by incorporating aspects of environmental and organisational change, economic and regulatory activities, and community development, as well as highlighting the importance of preventive health services.

Context is very important here. In the 1980s, there was a sense of frustration that public health as a discipline had become largely medicalised and somewhat absorbed with the use of epidemiological methods to provide ever more sophisticated explanations of observed population mortality and morbidity. There was less attention given to interventions that might address these observations and, where this existed, a strong focus on personal health 'risks' and lifestyle choices. Health education was correspondingly narrow in its content and mode of delivery, with much enthusiasm for the use of mass communication and emerging social marketing techniques, especially by governments. The Reagan era 'Just Say No' as the solution to an epidemic of illicit drug misuse was a perfect example of where this paradigm could take us.[1]

Our contribution to the *Health Education Journal* formed a part of a much wider international process that was supporting work in preparation for the World Health Organization's (WHO) first international conference on health promotion to be held in Ottawa in November 1986. John and I were both active contributors to the preparatory work for that meeting and the drafting of the conference documents, including the *Ottawa Charter* (WHO, 1986a). That Charter was intended to promote a serious paradigm shift in the way in which public health issues were conceptualised and addressed in the future – its sub-title was 'the move towards a new public health'. It has proven to be an enduring influence guiding the development of the concept of health promotion and in shaping public health practice in the past 30 years. It identifies five strategies – build healthy public policy, create supportive environments for health, strengthen community actions, develop personal skills and reorient health services – that have provided a framework to structure responses to many public health challenges since.

Although phrases such as 'full and continuous access to information' and 'learning opportunities for health' and the term 'education for health' are used, the specific term 'health education' is conspicuously absent from the Charter. I am unable to say whether this was by accident or design, but it represented a low point in appreciation of the importance of effective health education as the cornerstone of so much of what was advocated by the Ottawa Charter. It contributed to an unhelpful breakdown in relations between people and organisations who were already deeply invested in health education and those who were advocating for this paradigm-shifting 'new public health'.

Fortunately, these divisions have mostly faded, at least in part because there has been a more generous understanding of the role of health communication and education in empowering people and communities and in building public support for changes in public policy, alongside growing recognition that the content and methods of health education needs adaptation to meet new and different challenges.

Some years ago, I reflected on the fact that the highly influential journal *Nature* published a paper entitled Grand Challenges in Chronic Non-communicable Diseases (Daar et al., 2007; Nutbeam, 2008b) listing the top 20 policy and research priorities for conditions such as diabetes, stroke and heart disease. These challenges were grouped under six sub-headings that

included enhancing economic, legal and environmental policies; reorienting health systems; mitigating the health impacts of poverty and urbanisation; and engaging business and the community. These strategies appeared alongside more predictable calls for health education and raising public awareness.

I argued that 20 years before, such a structure for this paper would have been unimaginable. This is not simply because the science underpinning our understanding of non-communicable disease has advanced so significantly during this time but rather because there has been a paradigm shift in the way in which public health problems are conceptualised and addressed. Interestingly, the Ottawa Charter was not specifically referenced in the *Nature* paper, but I argued it was an example of the pervasive influence of the *Charter* and the compelling logic of its key strategies.

The magnitude of the impact of the Ottawa Charter belies the fact that it was developed at a relatively small WHO meeting (only 38 countries were represented) and was focused almost exclusively on the needs of 'industrialised countries'. These deficits have been progressively addressed through a series of more highly inclusive WHO Conferences on Health Promotion in the 30 years since Ottawa – the most recent being the 9th Global Conference being held in Shanghai, China in 2016 (Kickbusch and Nutbeam, 2017; WHO, 2016). These subsequent Conferences have, in different ways and at different times, sought to respond to changes in the world that could not have been anticipated by those drafting the Charter in 1986.

These changes include the globalisation of trade which has had a profound effect on the lives of all of us. The invention and development of the Internet and mobile communications have accelerated global connectedness, opened access to information and provided opportunities for communication that were not easily imagined at the time the *Charter* was written. New threats to health have emerged. HIV was barely understood at the time, and other health emergencies such as SARS and Ebola have appeared since. Changes to the profile of the burden of disease have occurred in both developed and developing countries, with non-communicable diseases emerging as the leading cause of death globally. People are on the move, migrating for in response to conflict and in search of greater economic opportunity at a level not experienced since the middle of the last century. These changes have had important health, social and economic consequences for all countries in the world. It follows that the meaning and relevance of the strategies first described in the Ottawa Charter continue to be challenged and need to be adapted.

The most recent WHO meeting in Shanghai provides a good illustration of how the concept of health promotion has proved to be resilient and capable of reinvention. The meeting was held in the wake of agreement on the United Nations Sustainable Development Goals (SDGs). It was the first (and so far only) WHO Global meeting to consider the potential role and contribution that WHO can make to the achievement of the SDGs including and beyond the health specific Goal 3. As has been the case with a majority of the WHO Global Health Promotion Conferences since Ottawa, there was wide representation of member states from all regions and significant participation of international organisations and sectors other than health.

The meeting and the subsequent Shanghai Declaration on promoting health in the 2030 Agenda for Sustainable Development (WHO, 2016) reflected a more complex world, but still contained at its core the strategies that trace their heritage to the Ottawa Charter (WHO, 2016). The document makes explicit that prioritising health will require difficult political decisions that address the commercial activities that have a profound influence on health. It prioritises good governance for health (echoing the importance of 'healthy public policy' and 'supportive environments for health'), support for local action through cities and communities (echoing 'strengthening community action') and people's empowerment by promoting health literacy (echoing 'develop personal skills'). In the latter priority, the Declaration states that, 'health literacy is founded on inclusive and equitable access to quality education and life-long learning. It must be an integral part of the skills and competencies developed

over a lifetime, first and foremost through the school curriculum'. This is music to the ears for those of us committed to health education as a foundation for health promotion.

The emergence of the concept of health literacy over the past 20 years has done much to bridge the perceived differences between health education and health promotion. Health literacy has long been described as a logical, measurable outcome to health education, an outcome that fits into a broadly based model of health promotion (Nutbeam, 1998). It has been defined and conceptualised in multiple ways (Peerson and Saunders, 2009; Sorensen et al., 2012) but is ultimately based on an observable set of skills that can be developed and improved through effective communication and education.

This can be limited to task-based communication – designed to develop specific skills to manage prescribed activities (medication adherence, behaviour change), but can also be skills based – educational activities that are designed to develop generic, transferable skills that equip people to make a range of more autonomous decisions relating to their health and to adapt to changing circumstances.

These transferable skills, often described as 'interactive' and 'critical health literacy' connect closely to modern concepts of health promotion (Nutbeam, 2000). Within this framing, health literacy has been viewed as a personal and population *asset* offering a route to greater autonomy and control over health decision-making (Mårtensson and Hensing, 2012; Nutbeam, 2008a; Pleasant and Kuruvilla, 2008). It is through this focus on skills development and empowerment that the concept of health literacy has had a distinctive influence on the purpose and methodologies of health education which, in turn, has evolved in content, media use and sophistication of communication.

Health literacy has become a very popular issue in the past decade with governments in many countries adopting national strategies to improve health literacy and an explosion in the number of research papers on the subject. However, there is a danger that the academic interest and attractive rhetoric surrounding the concept will get ahead of the objective evidence of its effectiveness, especially in the absence of consideration of the wider socio-economic context.

Research over the past decade has shown that context continues to have a profound impact on people's ability to translate their health literacy skills and capabilities into positive decisions and actions. Health literacy is mediated by the situational demands and complexities that are placed on people. Obtaining nutritional information from a food label is a quite different experience from receiving complex, jargon-laden instructions on how to manage diabetes, and quite different again from receiving information on childbirth at an antenatal clinic. Even a person with high level of health literacy may experience real challenges in applying those skills in an environment (like a hospital) or in interacting with a person (like a doctor) whom they find unfamiliar and intimidating. This has led to a further appreciation of the social, economic and environmental context for health education and communication – requiring greater attention to ways of reducing the situational demands and complexity in which an individual is acquiring information and/or making a health-related decision.

At this moment in the evolution of health literacy, it is important that different approaches to education and communication (content and method) are tested more often and more systematically through intervention experimentation in a wide range of populations and contexts to improve our understanding of what works under what conditions (Nutbeam et al., 2018). It is equally important that health education continues to be considered within the wider context of health promotion, as one of a number of complementary approaches to improving health in populations that also includes social mobilisation and political advocacy that may have a more profound impact on the social and economic determinants of health.

So, with the passage of time, much has changed and much remains the same. The tools for communication have been fundamentally transformed by digital communication, and the marketplace for communication is more crowded and complex. The content and mode of delivery of

health education has to continue to evolve to reflect these changes, to enable people to navigate competing sources of information and to engage meaningfully with social and economic determinants of health, as well as respond to personal risks. Health education has to help people develop transferable decision-making skills and not just achieve compliance with pre-determined health goals. Equitable access to quality health education and lifelong learning remain the cornerstones of modern health promotion.

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Note

1. Those unfamiliar with this reference can review the History Channel clip http://www.history.com/speeches/nancy-reagan-introduces-just-say-no-campaign

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