

# THE HEALTH PROMOTION ALIGNMENT FRAMEWORK

A Strategic Blueprint for Population Health



White Paper

The Health Promotion Alignment Framework:  
A Strategic Blueprint for Population Health

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This White Paper is intended to support international and intergovernmental dialogue, mandate development, policy design, and strategic implementation related to health promotion alignment across jurisdictions. It provides a foundational policy rationale and governance framework for strengthening structural action on the conditions that produce health across the life course.

While originally developed from work undertaken in the Canadian context, the core principles, framework logic, and implementation concepts presented here are designed for adaptation across diverse governance systems, institutional settings, and jurisdictional arrangements.

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## **Abstract**

This White Paper introduces the Health Promotion Alignment Framework, a governance architecture designed to help jurisdictions and institutions align action around the societal conditions that produce health across the life course.

It argues that medical systems remain essential but cannot, on their own, address rising chronic disease, mental health strain, widening inequities, workforce pressures, and unsustainable downstream costs. A more durable approach to health promotion is required: one that moves beyond fragmented programmes and rhetorical endorsement toward structured governance, shared accountability, positive outcomes, influencing factors, contributor domains, evidence-based strategies, and practical implementation mechanisms.

Originally developed from work undertaken in the Canadian context, the Framework is designed for adaptation across diverse governance systems, institutional settings, and jurisdictional arrangements.

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## CHAPTER 1

### The urgent case for health promotion alignment

#### Why now?

Many countries spend heavily on medical care, yet continue to see weak or uneven health outcomes relative to that investment. Despite massive expenditures, medical systems in many jurisdictions remain stuck in crisis mode, marked by overcrowded hospitals, workforce shortages and inefficiencies, rising chronic disease rates, and growing pressure across the continuum of care. The issue is not simply underinvestment. It is that too much public effort is absorbed by acute response because the upstream conditions that shape health have been neglected for too long.

In most places, policy and spending remain heavily concentrated on diagnosing and treating illness rather than creating the conditions that help people stay well in the first place. The result is a pattern that is now familiar across many societies: rising costs, worsening strain on medical systems, and avoidable deterioration in population health.

Many medical systems are approaching a breaking point. Acute and chronic disease, mental health challenges, and aging-related conditions are driving costs ever higher, even though many of the factors shaping those outcomes lie well beyond the traditional boundaries of medicine.

The consequences of this outdated approach are severe: fiscal unsustainability, as medical spending absorbs an ever larger share of public budgets without producing corresponding improvements in population health; declining workforce productivity, as chronic conditions increase absenteeism, disability, and burnout; and widening health disparities, as socially and economically marginalised populations continue to bear a disproportionate burden of ill health.

For years, political will has often been weak or inconsistent. Governments tend to prioritise immediate pressures, such as hospital capacity, workforce shortages, and near-term service demands, over longer-term health promotion investments. Political cycles reinforce that short-termism, making it difficult to sustain action whose most important gains may only become visible over time.

But the reality is clear: societies cannot treat their way out of this problem. No amount of hospital expansion or workforce growth, on its own, will reverse the broader tide of preventable chronic illness, psychosocial distress, and avoidable decline. If this trajectory continues, jurisdictions will remain locked in a downward spiral of rising costs, institutional strain, and worsening health outcomes.

To understand why the current approach continues to fail, we need to step back and ask a more basic question: what do we actually mean by health? Too often, the question is never asked. Health is still commonly treated as a physical end-state, something restored through medical treatment or pharmaceuticals. But that is only part of the picture, and often not the part that determines whether a person is truly able to live well.

## **Rethinking health: A paradox**

Health is not always what it seems at first glance. We assume we can recognise it when we see it, but the reality is more complex.

Imagine a scene where you are in a grocery store checkout line. Ahead of you is Ricardo, a man deep in thought, using a wheelchair. Behind you stands Suzanne, lean, well-dressed, smiling as she scrolls through her phone. Without giving it much thought, many people would assume that Suzanne is healthier than Ricardo. She is standing, appears fit, is mobile, seems cheerful, and has no visible disability.

But what if you knew more about them?

What if Ricardo were a Paralympic marathon medallist, training daily, fuelled by discipline and a deep sense of purpose, with strong relationships, social recognition, and a life he values deeply? And what if Suzanne were living in constant survival mode, struggling to put food on the table, enduring partner abuse, smoking to cope with longstanding depression, having just lost her job, and lacking the support, stability, and security needed to raise her three children in a healthy environment?

Now, who is healthier?

Or take Lucas, a senior executive admired for his discipline, performance, and polished success. He meets every deadline, presents well, and appears to be thriving. Yet beneath the surface he is sleeping poorly, eating poorly, carrying chronic stress, and ignoring the early signs of burnout. Then there is Martha, who is living with terminal cancer. Her life is profoundly constrained by illness, yet she has chosen to reconnect with family, travel while she still can, savour what remains, and live her final months with agency, support, and peace.

Health is not reducible to physical ability, professional status, or the absence of disease. It is also shaped by stability, security, meaning, connectedness, resilience, and the capacity to define and pursue a life one has reason to value.

This is where many systems go wrong. Access to treatment matters profoundly, but treatment alone does not create health. Suzanne may be able to receive care for a broken arm, but that will not by itself change the chronic stress of survival, the instability of poverty, the effects of abuse, or the conditions eroding her well-being. Health, and therefore health promotion, is about more than repairing what has gone wrong. It is about shaping the conditions that allow people to develop, adapt, participate, and thrive across the life course.

Until that distinction is recognised, societies will remain trapped in systems that are indispensable for treating illness yet insufficient for producing health.

This misunderstanding has real consequences. When health is treated as something achieved primarily through medical intervention, policy remains locked into a reactive cycle: rising costs, worsening outcomes, and widening inequities. The price of that misunderstanding is measured not only in dollars, but in lives constrained, opportunities lost, productivity diminished, and avoidable suffering carried forward across generations.

## **What's at stake?**

The financial, institutional, and workforce consequences of failing to prioritise upstream health promotion are already severe, and they will intensify if current trends continue. Public budgets are under growing strain as medical and illness-related costs crowd out other investments, forcing governments into repeated trade-offs between health, education, housing, infrastructure, and social supports.

Some jurisdictions have already begun to move in another direction, integrating health promotion more deliberately into governance, planning, and investment decisions. Their efforts remain uneven, but they point toward a different model, one that treats health not simply as the downstream output of medical care, but as something shaped by coordinated action across sectors and institutions.

If current trajectories continue unchecked, many governments will face deepening fiscal constraint, mounting service pressures, and increasingly difficult choices: higher taxation, service reductions elsewhere, rising debt burdens, or growing restrictions on access and quality. None of these resolve the underlying problem. They merely manage its consequences.

## A window of opportunity

There is now a widening opening for a more serious and coherent approach to health promotion.

First, **public tolerance for short-term, crisis-driven fixes is diminishing** as the pressure on medical systems becomes too visible to ignore. As wait times lengthen, workforce shortages persist, and medical systems remain under strain, frustration with reactive medical spending continues to grow. Taxpayers, employers, institutional leaders, and policymakers increasingly recognise that downstream rescue alone cannot secure long-term well-being or system sustainability. A more serious commitment to upstream health promotion is essential.

Second, **public understanding of health is changing**. Across many societies, there is greater recognition that mental health, social conditions, early development, built environments, economic security, and other structural influences play a decisive role in shaping well-being. The old assumption that health is simply the absence of disease is giving way, however unevenly, to a broader understanding.

Third, **governments and institutions are under increasing pressure** to show that they can think beyond emergency management. A more upstream and coordinated approach to health promotion offers something many systems now lack: a way to connect long-term social investment, practical governance, and measurable public value.

The opportunity, then, is not only to spend differently. It is to govern differently.

## What this White Paper proposes

This White Paper is not another abstract or conceptual discussion of health promotion. It offers a structured basis for action. It provides:

### **A strategic roadmap for implementation**

showing how jurisdictions and institutions can integrate health promotion into governance, planning, and funding arrangements without collapsing into conceptual vagueness or institutional conflict.

### **A clear case for policy and governance change**

demonstrating why a more aligned approach to health promotion is necessary for long-term social resilience, economic strength, and population well-being.

### **A practical framework**

the Health Promotion Alignment Framework, designed to help governments and other public actors align collective action across the life course, coordinate multi-sectoral effort, prioritise high-impact intervention points, and measure progress through positive health outcomes.

**Action-oriented direction**

identifying the kinds of leadership, coordination, implementation mechanisms, and institutional choices needed to move from a predominantly reactive model to a more sustainable and health-producing one.

Jurisdictions now face a clear choice. They can continue absorbing rising costs while tolerating preventable deterioration in health and well-being, or they can begin building a more coherent, upstream, and resilient approach, one capable of producing better outcomes over time.



## CHAPTER 2

### Lessons from the evolution of health promotion: From recognition to institutionalisation

#### Health promotion did not emerge yesterday

Health promotion is not a recent invention, nor is it a marginal add-on to more serious policy work. For decades, major reports, international declarations, reform efforts, and public-health thinkers have argued that health is shaped not only by medical care, but by the broader conditions in which people grow, live, work, relate, and age.

What has changed over time is not the strength of the idea, but the degree to which systems have been willing, or able, to organise around it.

One of the earliest and most influential shifts came in 1974 with **A New Perspective on the Health of Canadians**, widely known as the Lalonde Report. Whatever its limits, the report helped move public discourse beyond a purely medical model of health by arguing that health outcomes are shaped by far more than medical service delivery. Lifestyle, environment, human biology, and the organisation of care all mattered. That shift was significant. It challenged the assumption that better health would come primarily through expanding treatment capacity.

A few years later, the 1978 **Alma-Ata Declaration**, advanced through the World Health Organization, placed primary health care at the centre of the global “Health for All” agenda. Importantly, primary health care was not understood simply as first-contact medical service delivery. It was conceived more broadly, as a social and institutional approach that linked health to participation, equity, prevention, and action on underlying determinants.

Then, in 1986, the **Ottawa Charter for Health Promotion** gave perhaps the clearest and most enduring articulation of the field. It defined health as a resource for everyday life rather than merely the absence of disease, and set out a practical agenda: build healthy public policy, create supportive environments, strengthen community action, develop personal skills, and reorient health services. It remains one of the foundational documents in the history of health promotion

precisely because it captured something many systems still struggle to operationalise: health is produced across society, not only within medical institutions.

That same period also generated national and subnational frameworks, commissions, reform studies, and strategic reviews in many places. Some were ambitious, others more modest. But taken together, they reinforced several recurring conclusions: health is shaped by policies well beyond medical care, sustained action matters more than episodic initiatives, and meaningful progress requires health promotion to be embedded in governance rather than treated as a discretionary programme area.

These insights were not confined to one country. They circulated internationally and were adapted in different ways across jurisdictions. Some countries helped articulate them. Others institutionalised parts of them more effectively. In many cases, however, the ideas travelled further than the structures needed to sustain them.

That is the central lesson of this history. The conceptual foundations of health promotion have been well established for decades. The unfinished task has been institutionalisation.

## Why progress remained uneven

If the intellectual case for health promotion has been so strong for so long, why has progress remained so uneven?

### Politics

Part of the answer lies in politics. Health promotion often competes poorly in short electoral cycles because many of its most important gains are cumulative. Governments facing immediate pressures, hospital congestion, physician shortages, fiscal strain, or public anxiety about access to care, tend to gravitate toward visible corrective action. Acute interventions are easier to announce, easier to defend, and easier to measure within a short political horizon. Health promotion, by contrast, is often treated as long-term, diffuse, or optional, even when some of its benefits can in fact appear quickly.

### Myopic thinking

This short-termism is often reinforced by media narratives and populist rhetoric, which foreground visible crises such as wait times, workforce shortages, and hospital capacity far more readily than the structural conditions that produce health over time. In doing so, they can also deepen fear, narrow public expectations, and weaken the sense that longer-term, upstream action is both possible and worth pursuing.

## **Fragmentation**

Part of the answer also lies in institutional design. In many settings, health promotion is weakened by two overlapping forms of fragmentation.

The first is fragmentation of authority across levels of governance, especially in countries where responsibility is distributed across national, regional, state, provincial, territorial, or local institutions.

The second is fragmentation across sectors, professions, and organisational domains, where responsibility for the conditions that produce health is dispersed across education, housing, labour, planning, transport, social services, food systems, community development, and medical systems, among others.

These forms of fragmentation do not simply create inefficiency. They weaken accountability, dilute strategic ownership, and make it easier for health promotion to remain acknowledged in principle while neglected in practice. As a result, health promotion is often everyone's concern in theory and no one's organising responsibility in practice.

## **Focus on the medical model**

There is also the enduring problem of medicalisation. Even now, despite a social awakening of sorts, many people still equate health with the physical absence of disease, or with access to treatment when something goes wrong. That understanding is not trivial, because it shapes policy expectations, public debate, media narratives, and budget priorities. When health is understood mainly through the lens of illness and repair, systems become locked into a reactive posture.

More recently, the COVID-19 pandemic understandably reinforced treatment-first and crisis-management logics in many countries, further entrenching reactive understandings of health even as broader resilience remained essential. Pandemics and infectious disease threats are not new, and preparedness, prevention, surveillance, and emergency response remain essential public-health functions. The issue is not that these priorities should receive less attention, but that they should not absorb the public-health agenda so completely that longer-term health promotion, resilience, and the conditions that produce health are repeatedly displaced.

Medical care remains indispensable, but it is asked to compensate for social, developmental, environmental, and behavioural conditions it cannot by itself produce.

The narrowing of primary health care has compounded this problem. In much contemporary usage, primary care is often treated as a synonym for first-contact medical services. But in the broader WHO tradition, primary health care was meant to encompass health promotion, prevention, participation, and action on the determinants of health. Where that broader meaning

has been lost, systems tend to over-invest in downstream response while under-developing the upstream conditions of resilience and well-being.

## **Symbolism**

Another barrier has been the weakness of durable institutional mechanisms. Many governments and organisations have produced thoughtful declarations, strategies, or reform reports affirming the importance of prevention and health promotion. Yet too often these commitments remain symbolic. Without structures for coordination, shared accountability, continuity across political turnover, and implementation discipline, health promotion is repeatedly affirmed and repeatedly displaced.

In some jurisdictions, this pattern has been especially visible. Important concepts were articulated early. International influence was real. But implementation often remained uneven, fragmented, or vulnerable to shifting priorities. That experience is worth noting, not because it is unique, but because it illustrates a broader truth: conceptual leadership does not automatically translate into durable policy architecture.

Taking Canada as one example, this pattern was visible not only at the national level, but across provinces and territories as well. During the early 1980s and 1990s, multiple commissions, reform studies, and independent assessments examined the place of health promotion within broader health-system and social-policy reform. Their conclusions were strikingly consistent: health outcomes were shaped by policies far beyond medical service delivery, health promotion investment could yield both shorter- and longer-term value, and sustained political commitment would be required to embed health promotion into governance. Yet, as in many other countries, these efforts rarely translated into durable structural change. Fragmentation, weak implementation capacity, inconsistent coordination, and shifting electoral priorities repeatedly diluted their impact.

Even so, if no country has fully solved the problem of health promotion alignment, some have nevertheless moved further in embedding parts of it into governance.

## **Promising efforts**

The Nordic countries are often cited because they have taken a broader view of how public policy contributes to health. In countries such as Finland, Sweden, and Norway, health promotion has not been treated solely as a matter for medical systems. Elements of education, employment policy, local planning, family policy, and active transportation have all been used, to varying degrees, as part of a wider effort to support well-being. The lesson is not that these countries offer a perfect model, but that health becomes more tangible when it is built into ordinary governance rather than left at the margins.

Australia offers another instructive example. Its preventive health agenda has, at times, been framed more explicitly as part of the health system's long-term sustainability rather than as a separate or secondary concern. This has helped reinforce the idea that prevention and health promotion are not external to serious system planning, but integral to it.

Japan illustrates a different strength: the cultural and policy normalisation of lifelong health practices. Community-based programming for older adults, attention to movement and social connection, and a broader expectation that health is cultivated across the lifespan all point to an important principle. Health promotion is most durable when it is not treated only as a technical intervention, but as something woven into everyday life and social organisation.

The United Kingdom has contributed important thinking on the social determinants of health, not least through work associated with the Marmot tradition. That contribution matters because it helped make visible the patterned relationship between inequality, social conditions, and health outcomes. In doing so, it strengthened the argument that health promotion cannot be confined to individual behaviour change alone.

New Zealand's Wellbeing Budget is frequently noted because it attempted to shift public decision-making beyond narrow economic indicators and toward broader measures of social value, mental well-being, and community resilience. Whether or not such efforts fully deliver on their promise, they reflect an important move: treating health and well-being as central public goods rather than residual by-products of economic growth.

In some school settings in France, nutrition and mealtime have also been treated as part of wider social learning rather than a purely administrative function. That is a smaller example, but not a trivial one. It illustrates how habits, social norms, relationship to food, and the quality of everyday environments can be shaped through ordinary institutional design.

These examples differ in scale, ambition, and coherence. None, on its own, provides a complete template. Some are stronger on intersectoral policy, others on prevention, others on culture, early development, or social determinants. What they reveal, collectively, is that meaningful pieces of health promotion are entirely compatible with serious governance. They also reveal something else: even where progress has been real, it is often still partial. Strong initiatives exist, but are not always integrated into a single, explicit architecture that aligns outcomes, determinants, contributors, and evidence-based strategy across the life course.

That gap matters. It is the space in which many systems still lose coherence.

## The unresolved lesson

Taken together, the history of health promotion reveals a striking pattern.

The field has not suffered from a lack of ideas. It has not lacked major reports, international declarations, conceptual breakthroughs, reform language, or evidence that upstream conditions matter. What it has often lacked is a sufficiently durable means of organising action around those insights.

In too many settings, health promotion has remained rhetorically endorsed but structurally secondary. It is acknowledged in principle, but weakly embedded in funding logic, governance design, accountability arrangements, and cross-sector coordination. It appears in speeches, plans, and reports, yet struggles to achieve lasting institutional form.

This is why the challenge is no longer simply one of recognition. Recognition has been with us for decades. The unresolved challenge is alignment.

How can systems move from broad endorsement of health promotion to a more coherent architecture that links positive health outcomes, the conditions that shape them, the contributors capable of influencing them, and the evidence-based strategies most likely to make a difference?

That is the transition this White Paper seeks to support.

The lesson of the past is not that health promotion failed as an idea. It is that ideas, however compelling, do not reorganise systems on their own. Where health promotion has advanced, it has done so unevenly, often through partial institutionalisation, scattered reforms, or isolated areas of leadership. Where it has stalled, the barriers have usually been structural: fragmented authority, short-termism, medicalisation, weak coordination, and the absence of a practical governance model capable of holding the work together.

The task now is not to rediscover what earlier generations already understood. It is to build a more usable and disciplined means of acting on it.

That is the purpose of the Framework.



## CHAPTER 3

### The economic and policy case for health promotion

#### The cost of inaction

As this White Paper has already argued, rising costs, workforce shortages, and overburdened hospitals are not the root causes of the present crisis. They are symptoms of a broader structural problem: too many systems remain organised primarily to manage disease through medical service delivery rather than to promote positive health outcomes across the life course.

Without a stronger shift toward health promotion, medical spending will continue to rise, hospitals will remain under strain, workforce burnout will deepen, and governments will face growing difficulty sustaining both quality of care and broader social investment. The pressures now visible across many countries are not temporary disruptions. They reflect a deeper mismatch between how health is produced and how public systems are currently designed.

The case for health promotion is therefore not only a public-health argument. It is also an economic and policy argument of the first order. Beyond the ethical responsibility to enable people to live healthy, meaningful, and dignified lives, there is a compelling practical case for acting upstream. Effective health promotion can reduce avoidable long-term costs, improve workforce participation and resilience, strengthen social cohesion, and relieve pressure on downstream services.

If that shift does not occur, medical budgets will continue to absorb resources that might otherwise support education, housing, community infrastructure, social development, and other foundations of long-term well-being. Chronic disease, mental distress, and preventable decline will continue to erode productivity and strain public institutions. Health disparities will deepen, trapping already disadvantaged populations in further cycles of poor health and instability.

These are not isolated public-health concerns. They are systemic obstacles to sustainable social and economic development.

## The need for coordinated action across systems and jurisdictions

In many settings, efforts to promote health remain fragmented across sectors, institutions, and levels of governance. Important initiatives may exist in schools, communities, workplaces, local public health bodies, civil society organisations, or particular ministries, yet too often they operate in isolation, with limited coordination, inconsistent scale, and weak continuity over time.

This fragmentation is not merely inefficient. It is also an economic vulnerability. When health promotion is left dispersed across disconnected programmes and policy silos, systems fail to capture the full value of early action, positive development, and evidence-based health promotion. Avoidable illness continues to drive demand for costly downstream services. Workforce productivity suffers. Promising interventions remain underused or unevenly distributed. Governments and institutions spend more while weakening their ability to share learning, scale what works, and measure progress coherently over time.

Part of the problem lies in governance complexity. The conditions that produce health do not sit neatly within one ministry, one profession, or one institutional mandate. They are shaped by education, income, employment, care arrangements, social inclusion, housing, food systems, mobility, public space, community life, and medical care, among other domains. Yet few systems have practical mechanisms to align these actors around shared positive health outcomes.

This is especially challenging in countries where authority is distributed across national, regional, and local levels of government. But the problem is not limited to formal constitutional arrangements. Even within relatively centralised systems, responsibility for health-producing conditions is often fragmented across departments and agencies that plan, fund, and evaluate their work separately.

No single jurisdiction or institution can solve this alone. But neither does effective coordination require centralisation. The goal is not to erase difference or impose a single model. It is to create a structured basis for alignment, one that allows governments and institutions to retain implementation flexibility while still working toward coherent, measurable, and mutually reinforcing outcomes.

That is one of the central practical claims of this White Paper: health promotion will remain secondary until systems develop a disciplined way to align responsibility, evidence, investment, and action across the places where health is actually produced.

## Health as a public good: More than an economic asset

Although the economic case matters, health promotion should not be justified only in financial terms. Health is a public good and a foundation of both individual and collective well-being.

When individuals and communities experience positive health, they are not simply avoiding illness. They are better able to learn, work, form relationships, care for others, participate in community life, adapt to change, and pursue lives they have reason to value. A healthier population strengthens society in ways that no narrow cost-containment logic can fully capture.

It contributes to stronger social cohesion, because people in better mental, emotional, and physical health are generally better able to participate in family, community, and civic life. It contributes to greater resilience, because healthier individuals and communities are better equipped to manage stress, recover from setbacks, and withstand social or environmental shocks. It contributes to improved quality of life, because well-being is not reducible to economic output. And it contributes to a more adaptable and economically engaged workforce, because good health supports energy, concentration, reliability, and sustained participation.

The evidence is also increasingly clear that well-designed health promotion strategies can help reduce long-term demand on medical systems while generating both short- and longer-term returns. Some interventions, such as workplace mental health supports or targeted stress-reduction measures, can produce relatively near-term gains through reduced absenteeism, improved functioning, and greater retention. Others, including early childhood, family, and school-based strategies, may produce benefits over a much longer horizon by lowering the incidence of chronic disease, strengthening developmental trajectories, and reducing dependence on more intensive services later in life.

Both matter. Some returns are immediate, others cumulative. Together they reinforce the case for a more fiscally sustainable and socially serious approach to health.

When public policy focuses only on cost containment, it misses this wider value. The purpose of health promotion is not merely to spend less. It is to support dignity, opportunity, participation, resilience, and healthier development across the life course. The economic case is real, but it sits within a larger human and societal case that should not be obscured.

## Making health promotion tangible, legitimate, and politically durable

One reason health promotion is often under-prioritised is that it can seem abstract. It is easier to mobilise public attention around hospital wait times, emergency-room closures, or acute service shortages than around the slower, less visible erosion of the conditions that support health.

Yet health promotion is not abstract at all. It touches daily life at every stage of the life course: whether children can grow, learn, and develop well; whether young people have the support, relationships, and environments needed for healthy transitions; whether adults can maintain mental and physical well-being while navigating work, care, and social pressures; whether older adults can remain engaged, secure, mobile, and dignified.

Framed in that way, health promotion becomes easier to grasp as a matter of lived experience rather than policy rhetoric.

It is also politically more durable than is sometimes assumed. A serious health-promotion agenda can appeal across ideological lines, though for different reasons. It can resonate with those concerned about fiscal sustainability, because it seeks to reduce avoidable downstream costs and institutional strain. It can resonate with those concerned about equity and social justice, because it recognises that health is shaped by conditions that are unequally distributed. And it can resonate with those seeking practical, long-term governance solutions, because it offers a way to connect investment, health promotion, and measurable public value without reducing everything to partisan symbolism.

This is not about positioning health promotion against medical care. Medical systems remain essential. Physicians, hospitals, pharmaceuticals, and specialised treatment all play indispensable roles. But without stronger upstream effort, medical systems will continue to absorb pressures they were never designed to resolve on their own. Health promotion strengthens medical care by helping ensure that acute and specialised resources remain available where they are most needed.

Seen in these terms, health promotion is not a peripheral social-policy ambition. It is a governance priority.

## **From policy challenge to practical action**

For decades, many countries and institutions have acknowledged the importance of health promotion, well-being, and the broader determinants of health. What has often been missing is not awareness, but structural coherence.

The Health Promotion Alignment Framework is designed to address that gap. It offers a practical means of moving from general recognition to more disciplined action by linking positive health outcomes, influencing factors, contributor domains, and evidence-based strategies within a single planning and governance architecture.

Its value lies not in adding rhetorical ambition, but in making coordination more usable. It provides a way to align action across sectors and levels of governance without collapsing difference, creating unnecessary bureaucracy, or imposing rigid uniformity. It supports the

identification of shared priorities, the clarification of contribution and responsibility, the selection of evidence-based strategies, and the measurement of progress in relation to positive health outcomes rather than downstream failure alone.

In that sense, the Framework is not an alternative to serious policy and governance. It is a means of making them more coherent in relation to health.

The next chapter turns to the Framework itself: its structure, its core principles, and the fixed and flexible elements that allow it to be both disciplined and adaptable across different institutional and jurisdictional settings.



## **CHAPTER 4**

### **A blueprint for alignment**

#### **Overview**

The Health Promotion Alignment Framework offers a distinctive and unusually practical governance architecture for health promotion, bringing together strategic planning logic, positive-outcomes measurement, contributor-domain alignment, and an operational pathway for action across jurisdictions, sectors, and levels of governance.

Past approaches have often been either too rigid to adapt or too vague to implement, resulting in fragmented efforts and stalled progress. This Framework bridges the gap between ambition and execution, helping health promotion become an integrated, measurable governance priority rather than a theoretical concept.

Grounded in decades of rigorous research and evidence-based analysis, the Framework enables governments and all sectors to align efforts around shared positive outcomes, while allowing jurisdictional flexibility for priority-setting. The following section outlines its core principles and components in detail. A visual summary of the entire Framework is also available in the appendix, providing a high-level reference that complements the detailed descriptions below.

However, structure alone is not enough. Bringing the Framework to life requires deliberate implementation choices. The next chapter explores how alignment can be supported through governance arrangements, targeted institutional mechanisms, expert consultations and shared learning, and forms of coordination suited to different jurisdictional settings.

#### **Core principles and components of the Framework**

The Framework is built around six essential components that ensure a holistic, evidence-based, and results-driven approach. It provides a strategic backbone that is readily operationalisable while remaining flexible enough to suit the needs and priorities of different jurisdictions. This practical orientation helps distinguish the Framework from models that primarily describe the

conceptual foundations of health promotion without providing a comparable structure for alignment and implementation.

As a starting point, the Framework provides a logical structure for organising its core content: positive health outcomes and the factors that shape them. It brings together the following research-based concepts in a clear visual model designed to support alignment around key priorities for action:

1. A focus on the **entire life course**.
2. A structuring of the life course around a series of **developmental transitions**, and the increasingly complex social environments people must navigate as they grow, play, learn, work, age, and contribute to society.
3. A focus on the achievement of **positive outcomes**, reflecting the promotion of health as a positive construct rather than only the elimination or reduction of negative states of health.
4. A breakdown of each positive outcome into a prioritised set of measurable **influencing factors** that shape a person's ability to achieve that outcome.
5. The recognition that all sectors, not only governments or medical systems, are **contributors** to positive health outcomes across the life course through their capacity to act on key influencing factors.
6. A structured inventory of evidence-based, actionable **strategies** that contributor domains can apply. This practical, results-oriented focus helps distinguish the Framework from models that mainly describe the conceptual foundations of health and social policy. These strategies answer a practical question: what can each contributor domain do to support positive health outcomes?

A visual representation of the above six core components of the Framework can be found as Appendix B, providing a structured illustration of how they align to create a comprehensive, outcome-driven approach to health promotion.

### **A note on alignment**

The word **alignment** in the Framework's title is intentional. It signals a shift from scattered, one-off initiatives to a coordinated, measurable, results-driven effort across all sectors of society—one that eliminates duplication, optimises resources, and creates lasting impact.

Right now, health promotion often resembles a jurisdictional and sectoral tug-of-war. Different governments, organisations, and sectors are pulling in different directions, often with good intentions but without a shared structure for coordination. The result is siloed effort, duplication, strained resources, and missed opportunities for real cumulative impact. The Health Promotion Alignment Framework is designed to help move these actors beyond silos and toward a more coherent, mutually reinforcing approach, one aligned around shared positive outcomes across the life course.

Most countries do not lack health promotion initiatives; they lack a durable means of connecting, scaling, and sustaining them. The Framework provides a structured mechanism to unify these efforts, ensuring that evidence-based interventions are not just developed in isolation but systematically embedded into policy and practice at every level of society. By aligning efforts strategically, we eliminate fragmentation, maximise impact, and achieve efficiencies of scale across all socio-economic domains that contribute to population health.

### **A focus on the entire life course**

Health is not static—it evolves over a lifetime. While early investments provide a strong foundation, they are not enough. Individuals need sustained opportunities to build, maintain, and restore their health at every stage of life, whether it's a child gaining resilience in school, an adult navigating work stress, or an older adult maintaining independence. Seniors groups have long advocated to be seen as vibrant, contributing members of society rather than a financial burden to medical systems and drug plans. The Health Promotion Alignment Framework ensures that opportunities for well-being, recovery, and resilience exist throughout life, even for those who did not benefit from a healthy start.

This point reinforces that health promotion strategies should not be front-loaded only in childhood, but remain a priority through every key developmental transition. Research demonstrates that healthy behaviours and supportive conditions at any age can help reduce morbidity, extend lifespan, and improve quality years of well-being. Policies and programmes supporting individuals to: develop secure attachment as a newborn, be more physically active; eat well; go back to school; earn a stable income; benefit from healthier relationships; participate in community-building; and increase their mobility and independence – are all sound investments that have been demonstrated as effective means to the reduce chronic disease and mental illness burden in modern societies.

### **A focus on successful developmental transitions**

The concept of developmental transitions suggests that the process of growing up and aging requires a person to successfully adapt to a series of ever more complex social environments. This begins in the mother's womb, then the immediate family and/or primary caregivers, the school, the neighbourhood and community, workplaces and society as a whole. While these transitions generally follow the human lifespan, they are not strictly age-based. Instead, they represent flexible periods within which individuals progress to their next stage.

This construct provides a logical structure for collective effort and for the very argument for multi-sectoral solutions to complex social issues that determine people's health. This is not just about funded government programmes.

Each stage of life brings distinct opportunities and challenges. Ensuring children adapt well to school, helping adolescents build resilience, and supporting adults in maintaining economic

stability and relationships all contribute to healthier aging. A combination of well-structured policies, supportive environments, and individual agency is required to help individuals navigate these transitions successfully—moving from young adulthood through middle age with independence and minimal morbidity.

The Health Promotion Alignment Framework is structured around seven key developmental transitions that people navigate throughout life. These categories were developed through extensive consultations across diverse fields, including child development, aging, health and social services, and multi-sectoral research. Socio-demographic and neurological evidence further refined these stages, highlighting how traditional assumptions—such as equating "old age" with dependence—no longer hold. Older adults in their 70s, 80s, and beyond remain active contributors in the workforce and community, and research on brain plasticity confirms that learning and personal growth continue throughout life. This evidence reinforces the need for a framework that supports health at every stage—not just in early life but across the full lifespan.

***For each of the developmental transitions, the Framework identifies a number of positive outcomes that tell us that a person is doing well. These outcomes are like landmarks that indicate the child, youth, adult or older adult is on the right path in their development and aging process at any given time in their life.***

The Health Promotion Alignment Framework provides a short list of positive health outcomes under each of the following developmental transitions individuals navigate over their life course:

**Transition 1** – To Birth & Early Childhood (before ~age 1)

**Transition 2** – To Middle Childhood (before ~age 5)

**Transition 3** – To Adolescence (before ~age 12)

**Transition 4** – To Young Adulthood (before ~age 20)

**Transition 5** – To Middle Adulthood (before ~age 40)

**Transition 6** – To Older Adulthood (before ~age 80)

**Transition 7** – To End of Life (before and up to end of life)

## **A focus on positive health outcomes**

Perhaps the most important concept of the Framework is its emphasis on positive outcomes as the ultimate goal. This distinguishes health promotion from one of its many corollary benefits: disease prevention. This focus is closely linked to supporting successful developmental transitions across the life course.

Rather than concentrating solely on eliminating negative outcomes for some, the Framework prioritises what we want to achieve for all. The positive outcomes identified in the Framework serve as clear goals to guide our policies, actions, programmes, and services.

Simply stated, we cannot achieve health by focusing only on avoiding disease. This does not mean that at-risk populations or those suffering from negative health conditions do not require tailored medical (or other) interventions. However, it reinforces a key principle of health promotion: the best way to support those who need it most is by fostering conditions that enable all individuals to thrive. For each developmental transition, the Framework identifies a number of positive outcomes that indicate whether a person is doing well—i.e., whether they possess the necessary conditions to make a healthy transition to the next stage in life.

These outcomes serve as key landmarks, signalling whether a child, youth, adult, or older adult is on a healthy developmental path as they age.

The Framework's focus on positive health outcomes rather than deficit-based measures is deliberate. Currently, most medical systems predominantly react to problems rather than shaping the wider conditions that produce health. Health promotion is often mistaken for disease prevention, but they are not the same. While prevention seeks to reduce risks and avoid illness, health promotion actively creates the conditions for well-being. Disease prevention may be a byproduct of strong health promotion, but the goal is broader—ensuring people thrive, not just avoid getting sick. It's almost as if we believe that in our attempts to treat or avoid illness at all cost, we will automatically be healthy. But as the definition of health itself states, it is more than the mere absence of disease.

And you get what you aim for—if we only measure what we want to avoid, how will we ever achieve what we want to achieve? By setting clear, measurable targets for positive health outcomes at every stage of life, the Framework ensures health promotion is about actively creating the conditions for lifelong well-being.

As mentioned earlier, despite frequent rhetoric about the importance of upstream investments, medical spending remains overwhelmingly focused on diagnosing and treating illness rather than fostering health. The Framework prioritises what we know works to achieve health, rather than defaulting to the costly infrastructure of screening and medical service delivery. While clinical care is and will always be essential, it is not the same as shaping the environments and behaviours that keep people healthy in the first place.

Yet, most countries' health surveillance systems still track morbidity and mortality data. In strategic planning, the principle is simple: you achieve what you aim for, measure and report on. Without a defined set of measurable positive health outcomes, and a surveillance infrastructure that begins to include them as part of their mandate, we continue reinforcing systems designed to treat and document decline rather than drive well-being. A system that only quantifies what goes wrong will never be designed to ensure things go right.

## **A focus on influencing factors for each outcome**

For each positive health outcome, the Framework identifies a set of key influencing factors—the conditions that determine whether an individual can realistically achieve that outcome. These factors act as levers for change, shaping health not in isolation, but through complex, interdependent relationships.

Rather than listing every possible factor, the Framework prioritises those that research and expert consensus have identified as most impactful and actionable. This targeted approach ensures that health promotion strategies focus on the highest-value efforts. Those with the greatest potential to help attain each positive outcome under which it is aligned.

However, these factors rarely act in isolation. They interact in complex ways, and ideally, amplify one another. For example, a child’s ability to develop age-appropriate emotional and social skills is influenced by parental beliefs and expectations, the school environment, and access to community programmes, to name but a few, and not just by individual effort. Similarly, an older adult’s capacity to remain independent depends on housing, mobility infrastructure, social support networks, and financial security.

The Framework ensures that policy and investment decisions are grounded in these realities, recognising that achieving positive health outcomes requires more than just medical interventions alone—it requires a coordinated, cross-sectoral approach that addresses the real-world conditions shaping people’s health.

## **A focus on multiple sectors as contributors to health**

Effective health promotion is not the sole responsibility of individuals, governments, or medical systems. As mentioned repeatedly, it requires shared leadership and collective action across multiple sectors that shape the conditions in which people live, work, and age.

Socio-ecological models highlight how all sectors influencing health are interconnected, reinforcing that health is shaped by more than just personal choices. Health promotion extends beyond individual behaviours—it depends on the broader systems that shape them, including policies, environments, and social supports.

The Framework identifies nine key contributors to health, each playing a distinct but interconnected role in shaping population well-being. These contributor domains are often illustrated, in socio-ecological models, as concentric circles, starting with the individual in the centre.

1. **Individuals** — Personal behaviours, capacities, identities, and lived conditions shaped by broader social, economic, cultural, and environmental influences.
2. **Families** — Parents, caregivers, siblings, extended family members, and significant others who shape early development, emotional support, caregiving, stability, and belonging across the life course.
3. **Schools** — Educational settings and learning communities that influence development, health literacy, socialisation, confidence, and future opportunity.
4. **Communities** — Neighbourhoods, local networks, community organisations, social cohesion, and built and natural environments that support connection, safety, participation, and resilience.
5. **Civil society** — Non-governmental and voluntary organisations, advocacy bodies, and community-based groups that provide support, mobilise action, and strengthen social capacity beyond the state and the market.
6. **Workplaces** — Employment settings, working conditions, organisational cultures, and economic opportunities that shape adult health and well-being, while also influencing family life, caregiving, and home stability.
7. **Medical systems** — Care institutions, services, and professionals that influence treatment, care, support, early intervention, and the management of physical and mental health conditions.
8. **Private sector** — Commercial actors, market institutions, industry, media and platform companies, and business practices whose decisions, products, services, and environments can support or undermine health.
9. **Governments** — Public authorities and institutions at different levels that shape health through policy, regulation, funding, coordination, service design, and as employers.

By explicitly recognising these nine domains, the Framework reinforces a fundamental shift: health promotion is not a medical-system issue alone—it is an economic, social, and governance priority. This perspective moves us beyond the outdated assumption that health is the sole domain of medical service delivery and instead positions all sectors as active contributors to improving population health and well-being.

### **A note on cross-cutting forces**

Media, social media, and AI-enabled technologies are not treated here as a separate contributor domain category because their influence is cross-cutting. Structurally, they are addressed through the contributor domains that shape them, the influencing factors they affect, and the evidence-based strategies available to respond. Depending on context, they may operate through the private sector, governments, schools, workplaces, medical systems, civil society, communities, families, or individuals, while influencing such factors as norms, beliefs, trust, connectedness, identity, attention, safety, and access to information.

For example, in adolescence, social media may shape influencing factors such as self-image, belonging, expectations, sleep, and exposure to harmful content, while different contributors, including families, schools, governments, civil society, and platform companies, may each have distinct roles in responding.

### **Why this matters**

When all sectors align their efforts, the impact is greater than the sum of its parts—policies reinforce one another, investments generate long-term returns, and individuals benefit from an environment that actively supports health at every stage of life.

Health promotion cannot succeed in silos. The Framework ensures that every contributor—whether a parent, policymaker, employer, educator, or community leader—understands their role and has the tools to drive meaningful change.

### **A focus on effective strategies**

For health promotion to succeed, it must be grounded in action. The Framework prioritises evidence-based strategies—proven actions, programmes and interventions that actively support health and well-being. These strategies operate at multiple levels, spanning policy, programmes, environments, and individual behaviours. Strategies must have a strong evidence base to ensure they actually work. Otherwise, behaviours, programmes, and policies—however well-intentioned—risk failing to contribute to the positive outcomes we seek to achieve.

The Framework’s approach ensures that strategies are:

**Targeted** – Addressing key influencing factors that shape positive health outcomes.

**Evidence-based** – Backed by research and measurable impact.

**Multi-sectoral** – Engaging all levels of government, businesses, NGOs, and communities.

**Scalable** – Adaptable for diverse populations and jurisdictions.

These strategies often fall into four key categories of action.

**1. Policies** – Structuring environments that enable health:

- Child policies that ensure access to high-quality education, nutrition, and family support.
- Urban planning policies that promote walkability, green spaces, and active transportation.
- Tax incentives that encourage healthy food access and workplace wellness programmes.
- Labour policies that promote job security, flexible leave policies for parents, fair wages, and mental health supports.

**2. Programmes** – Direct interventions with measurable impact:

- School-based health education programmes to promote nutrition, mental well-being, and physical activity.
- Workplace mental health initiatives that reduce absenteeism and increase productivity.

- Community-based seniors' programmes that support aging in place and prevent social isolation.

**3. Communications & Social Change** – Shaping attitudes, behaviours, and norms:

- Public health campaigns that shift social norms around physical activity, substance use, and healthy eating.
- Media literacy programmes that help individuals critically assess misinformation about health.
- Workplace and school initiatives that promote mental health literacy and resilience.

• **4. Individual Actions** – Supporting healthier choices through enabling environments:

- Encouraging active transportation by ensuring safe cycling and pedestrian infrastructure.
- Promoting nutritional literacy through clear food labelling and education.
- Supporting lifelong learning and skill development for economic and social stability.
- Reducing harmful substance use by fostering environments that discourage smoking and illicit drug use through education, early intervention, and supportive community programmes.

Moving from concept to action requires a thoughtful approach that balances consistency with flexibility, allowing for coherence across jurisdictions while preserving implementation flexibility.

## Fixed and flexible elements of the Framework

The following table outlines the fixed structural elements that ensure coherence across jurisdictions and the flexible components that enable adaptation, ensuring that all jurisdictions and sectors can effectively contribute to and benefit from a stronger, healthier population.

Fixed Element	Flexible Elements
<p><b>1. Life course structure</b> Health promotion efforts are aligned around key developmental transitions across the life course.</p>	<p><b>1. Implementation timelines</b> Jurisdictions determine their own rollout strategies based on their priorities and capacities.</p>
<p><b>2. Positive outcomes and influencing factors</b> Progress is tracked through positive outcomes and their influencing factors across each developmental transition, rather than relying primarily on morbidity or disease-reduction metrics.</p>	<p><b>2. Targeted strategies</b> Jurisdictions can emphasise the strategies most relevant to their population’s needs, context, and emerging lessons.</p>
<p><b>3. Alignment across contributor domains</b> Health promotion is strengthened when all contributor domains coordinate action and reduce fragmentation.</p>	<p><b>3. Funding mechanisms</b> Jurisdictions retain flexibility in how they allocate resources within the framework.</p>
<p><b>4. Evidence-based strategy logic</b> Strategies should be grounded in credible evidence, linked to influencing factors, and designed for measurable impact.</p>	<p><b>4. Public messaging and communications</b> Governments and institutions can tailor health promotion narratives to different audiences and contexts.</p>

The next chapter explores how to move from strategic vision to sustained impact. While the Health Promotion Alignment Framework provides the foundation, success depends on effective implementation. This requires structured mechanisms that allow contributors across sectors and institutions to collaborate, share knowledge, and measure progress. The following chapter outlines key approaches that could support long-term, coordinated alignment and action.



## CHAPTER 5

### From framework to implementation: Making it happen

The Health Promotion Alignment Framework is not self-executing. Its value lies not only in the clarity of its architecture, but in its capacity to be used, adapted, and sustained over time. If health promotion is to move beyond endorsement in principle, it must be embedded in governance, planning, funding, implementation, and accountability in ways that outlast short-term enthusiasm and episodic reform, strengthen positive health outcomes across the life course, and reduce avoidable downstream costs and pressures over time.

That is the real implementation challenge.

Many countries and institutions already recognise that health is shaped by far more than medical care. They understand, at least broadly, that the conditions of childhood, education, employment, housing, care, social connection, income, built environments, and community life all influence whether people are able to thrive across the life course. Yet recognition alone does not create durable change. Without structure, coordination, and institutional follow-through, health promotion remains vulnerable to fragmentation, policy drift, and political short-termism.

The Framework is designed to help close that gap. It offers a way to organise health promotion as a coherent governance project rather than as a loose collection of good intentions. But for that to happen, implementation must be treated as a serious design task in its own right.

### Strategic implementation: A structured, flexible rollout

Implementation should not be understood as a one-time act of adoption. It is a long-term alignment investment, a process of embedding a shared architecture into the practical realities of institutions, sectors, and jurisdictions over time.

As previously outlined, the Framework includes both fixed and flexible elements. The fixed elements preserve the integrity of the architecture: the life-course structure, the developmental transitions, the positive health outcomes, the influencing factors, the contributor domains, and the requirement that strategies be evidence-based. Together, these form the strategic planning

logic of the Framework. They are not meant to be reinvented jurisdiction by jurisdiction, because once those core elements become negotiable, the coherence of the model begins to collapse. They are what allow the Framework to function as a common structure for alignment.

At the same time, implementation must remain flexible enough to respond to differing institutional settings, governance arrangements, population needs, political cultures, and capacities. Jurisdictions may choose to prioritise different influencing factors first. They may sequence action differently. They may rely on different governance arrangements, implementation mechanisms, communications approaches, or institutional designs. That flexibility is not a weakness in the model. It is part of what makes the Framework usable across diverse contexts.

A structured rollout therefore requires more than rhetorical commitment. It requires deliberate choices about where to begin, how to phase implementation, how to build shared understanding, how to maintain continuity, and how to track progress over time. In some settings, implementation may begin with a focused application to one developmental transition or one cluster of outcomes. In others, it may begin with a cross-sector planning exercise, a pilot initiative, or a government-led effort to establish a common language and measurement base.

What matters is not that every setting proceed identically. What matters is that implementation remain recognisably aligned to the architecture of the Framework and disciplined enough to avoid fragmentation.

## Shared responsibility across institutions, sectors, and jurisdictions

Health promotion alignment cannot be implemented by any single institution, sector, or level of government acting alone. The conditions that produce health are shaped across many domains of life and therefore require contribution from a wide range of actors.

Governments and public institutions have an essential enabling role. They can shape policy, regulation, funding, incentives, service design, public communications, convening structures, and longer-term stewardship. They can create the conditions within which health promotion becomes more coherent, visible, and durable. In many settings, they are also major employers, service providers, and institutional actors in their own right, with a direct influence on health-producing conditions.

But governments do not produce health alone.

Implementation also depends on the active contribution of the full range of contributor domains identified in the Framework: individuals, families, schools, workplaces, communities, civil society, the private sector, medical systems, and governments. Each has different capacities, different forms of influence, and different points of leverage across the life course. **Individuals** exercise agency within the conditions available to them, making personal behaviour important while never treating it as detached from social, economic, cultural, and environmental context.

**Families** shape early attachment, caregiving, stability, and belonging. **Schools** shape development, socialisation, confidence, and health literacy. **Workplaces** shape income, stress, time, security, and the ability to balance employment with caregiving and personal well-being. **Communities** shape connection, participation, safety, and the quality of everyday environments. **Civil society** strengthens support, advocacy, mobilisation, and local innovation. The **private sector** influences commercial practices, employment conditions, product and service environments, and, increasingly, media and digital environments that can either support or undermine health. **Medical systems** remain indispensable in treatment, care, support, early intervention, and the management of physical and mental health conditions. **Governments** shape the wider policy and institutional context within which all of this occurs.

Shared responsibility, however, does not mean identical responsibility.

Different contributors will not, and should not, play the same role. Their responsibilities differ according to mandate, authority, reach, resources, and relationship to particular developmental transitions, outcomes, and influencing factors. The task is not to assign equal obligations to all actors, but to create a practical basis for differentiated contribution within a shared architecture.

That is particularly important in multi-level governance settings. In some countries, implementation may require coordination across national, regional, and local governments. In others, institutional leadership may sit more clearly at one level, with adaptation occurring elsewhere. Some settings may rely more heavily on public institutions; others may depend more on civil society networks, local governments, or collaborative platforms that bridge sectors. The architecture should be capable of travelling across those differences without collapsing into vagueness.

Without such coordination, even well-intentioned efforts tend to remain siloed. Contributors may work in parallel, duplicate one another's efforts, overlook important gaps, or pursue competing priorities without a shared means of aligning action around positive health outcomes. The result is not only inefficiency. It is the loss of cumulative impact.

## Implementation mechanisms

To move from strategic alignment to sustained impact, implementation needs practical mechanisms. These should not be understood as a rigid template, nor as an exhaustive list. Rather, they are examples of the kinds of structures, tools, and activities that can help health promotion become more durable, coordinated, and measurable over time.

### Recurring implementation roundtables and working forums

These can bring together relevant contributors across sectors, institutions, and jurisdictions, including researchers and evaluators where appropriate, to refine priorities, validate assumptions, share emerging evidence, and strengthen collective ownership. Used well, they are

not merely consultative. They can serve as working spaces for alignment, problem-solving, and disciplined adaptation, including the validation and contextual refinement of outcomes, influencing factors, and implementation choices.

### **An implementation symposium or shared learning platform**

A broader forum of this kind can help sustain momentum, support exchange across settings, surface lessons from early adopters, and strengthen visibility across the wider field of practice. It can also help ensure that health promotion alignment remains an evolving endeavour, capable of responding to new evidence, technological change, and broader social shifts over time.

### **A coordinated data-gathering and reporting strategy**

If health promotion is to be treated seriously, it must be visible and measurable in the right ways. Shared indicators, structured reporting, and accessible data systems can help track progress in relation to positive health outcomes and their influencing factors, not simply morbidity, service utilisation, or downstream system strain. This makes it possible to identify gaps, support accountability, and build a clearer picture of whether jurisdictions are actually improving the conditions that produce health.

Over time, such reporting could also support comparative learning, country-level report cards, and broader efforts to develop more robust indices of health promotion alignment. In some settings, this function may be best supported by an independent or arm's-length entity capable of ensuring continuity, comparability, technical credibility, and public trust.

### **An open-access inventory of evidence-based strategies**

Over time, a structured repository of strategies, organised by contributor domain, developmental transition, outcome, and influencing factor, could help reduce duplication, strengthen policy learning, and support more disciplined adaptation across settings. Such a resource would make it easier to focus on approaches that have demonstrated value, avoid diffuse effort and the repeated recycling of weak or untested initiatives, and build a more cumulative and practically usable field of action.

### **An innovation fund or challenge-based funding stream**

Carefully designed funding mechanisms can support experimentation, pilot initiatives, adaptation across contexts, and the scaling of promising approaches. The point is not novelty for its own sake, but disciplined experimentation linked to measurable outcomes and learning. Priority should be given to initiatives that can demonstrate measurable value, generate transferable learning, and show potential for adaptation across different settings.

### **A policy fellowship, exchange, or secondment model**

Cross-sector and cross-jurisdictional learning can be strengthened when policy leaders, researchers, practitioners, and institutional actors have structured opportunities to work across settings, transfer knowledge, and learn from implementation in real time.

**A standing leadership council or advisory platform**

Such a body can provide continuity, strategic reflection, and cross-sector dialogue, especially in contexts where political turnover or institutional fragmentation repeatedly interrupt longer-term work.

**A public communication and social marketing strategy**

Health promotion will remain vulnerable if it is poorly understood. Public-facing communication can help reinforce the understanding that health is not reducible to medical care, that positive outcomes matter, and that health-producing conditions are shaped across daily life. It can also help shift public and institutional narratives away from crisis-only thinking. In contemporary settings, this must include attention to media, social media, and digital environments as cross-cutting forces that influence norms, trust, expectations, and public understanding.

In many settings, this will also require disciplined change-management practice and, where appropriate, social marketing approaches that help shift understanding, expectations, and behaviour over time.

**Public-facing dashboards or investment indices**

Implementation can be strengthened through dashboards or indices that make commitments, patterns of investment, and progress more visible. Used carefully, such tools can encourage transparency, support comparison and learning, and help keep health promotion from receding into abstraction.

No single setting will require all of these mechanisms in the same form. Nor should implementation be reduced to a checklist. What matters is that jurisdictions and institutions choose mechanisms capable of supporting continuity, learning, coordination, and accountability over time.

**From commitment to institutionalisation**

The challenge, then, is not simply to persuade people that health promotion matters. That case has been made many times before. The deeper challenge is to give health promotion durable institutional form.

Too often, health promotion is endorsed rhetorically but remains secondary in practice. For decades, and in multiple reports and reform efforts across many settings, health promotion has appeared in strategies, speeches, action plans, and policy documents, yet still too often lacks the governance arrangements, coordinating structures, implementation pathways, and sustained attention needed to remain central over time. When that happens, effort becomes episodic, fragmented, and vulnerable to political change.

The Health Promotion Alignment Framework is meant to help shift that pattern. It does not offer a single programme or a universal implementation template. It offers a governance architecture capable of holding complexity without surrendering coherence. It enables jurisdictions and institutions to work within a shared structure while retaining room for adaptation, sequencing, and context-sensitive choice.

That is what gives the Framework its practical significance. It is a way of moving from broad commitment to usable alignment, from aspiration to implementation, and from scattered effort to a more disciplined and cumulative form of action.

If adopted, adapted, and tested across diverse countries, jurisdictions, and institutional settings, a governance architecture of this kind could, over time, help inform international guidance, comparative learning, shared standards, and broader multilateral efforts to strengthen health promotion alignment across jurisdictions. That is not the immediate task, but it is one of the reasons implementation now matters so much: what is made durable in practice can, over time, shape what becomes institutionally and internationally possible at a larger scale.

The task ahead is therefore both practical and structural. It is to ensure that health promotion no longer remains an acknowledged priority without a sufficiently durable means of implementation. The question is no longer whether the conditions that produce health matter. The question is whether institutions and jurisdictions are prepared to organise around that reality with enough seriousness, discipline, and continuity to make a lasting difference.



## APPENDIX A

### Redefining health, rethinking systems and behaviours

As described throughout this White Paper, health has long been viewed through a narrow medicalised lens, as a physical end-state achieved through the treatment of illness or disability, rather than as a means to an end: a resource for everyday living that enables people to thrive. Yet decades of research and the rethinking of socio-psychological constructs have shown that health is far more than the absence of illness. It is the capacity to live with stability, security, joy, and purpose. It is shaped by the environments in which we live, work, learn, and age, not only by the medical care we receive.

Many countries built their systems of medical care around a necessary and often historic commitment to universal access to treatment and care. That achievement mattered deeply. But in many settings, the broader project of modernising those systems to reflect a fuller understanding of health never advanced far enough. Medical systems remained essential, but they also became overburdened by expectations they were never designed to meet on their own.

Canada offers one illustrative example. It played an important role in early health promotion thinking and in broadening discussion beyond medical care alone. Yet, like many countries, it continued to invest overwhelmingly in hospitals, physicians, pharmaceuticals, and acute service delivery, without developing a comparably durable architecture for aligning the wider conditions that produce health.

These conditions, often described as the determinants of health, include such factors as safety, housing, education, income security, social inclusion, and environmental quality. They lie partly outside the traditional boundaries of health policy, yet they are among the most powerful drivers of long-term well-being. The challenge, then, is not simply one of awareness. It is one of alignment: how to organise action across sectors so that these conditions are addressed in a coherent, outcome-oriented way rather than acknowledged abstractly and left structurally disconnected.

## Clarifying the role of behaviour

For decades, health promotion was often interpreted largely through the lens of lifestyle or behaviour modification: eat better, move more, stop smoking. That framing was understandable at the time, but it also encouraged an overemphasis on individual responsibility at the expense of structural conditions.

The Framework does not dismiss the importance of personal agency or healthy behaviours. Some of the positive health outcomes it identifies do involve areas such as physical activity, healthy eating, and the ability to make informed choices. But individual behaviour does not arise in a vacuum. It is shaped by the physical, social, cultural, and economic environments in which people grow up, live, play, learn, work, and age.

More importantly, many of the outcomes that signal whether someone is truly healthy in a life-course sense are not captured by physical or clinical measures alone. They are social, emotional, developmental, and economic. Housing security, emotional resilience, meaningful connection, the capacity to make informed choices, and a sense of belonging are not only influencing factors; they are themselves evidence of health.

By structuring the Framework around positive outcomes and their key influencing factors, the White Paper moves beyond the outdated view that health is a physical end-state defined mainly by the absence of disease and secured primarily through access to medical treatment.

Health is better understood as a shared outcome, shaped by systems, structures, environments, and relationships, as well as by individual agency. This is the perspective that underpins the Framework's architecture.

## APPENDIX B

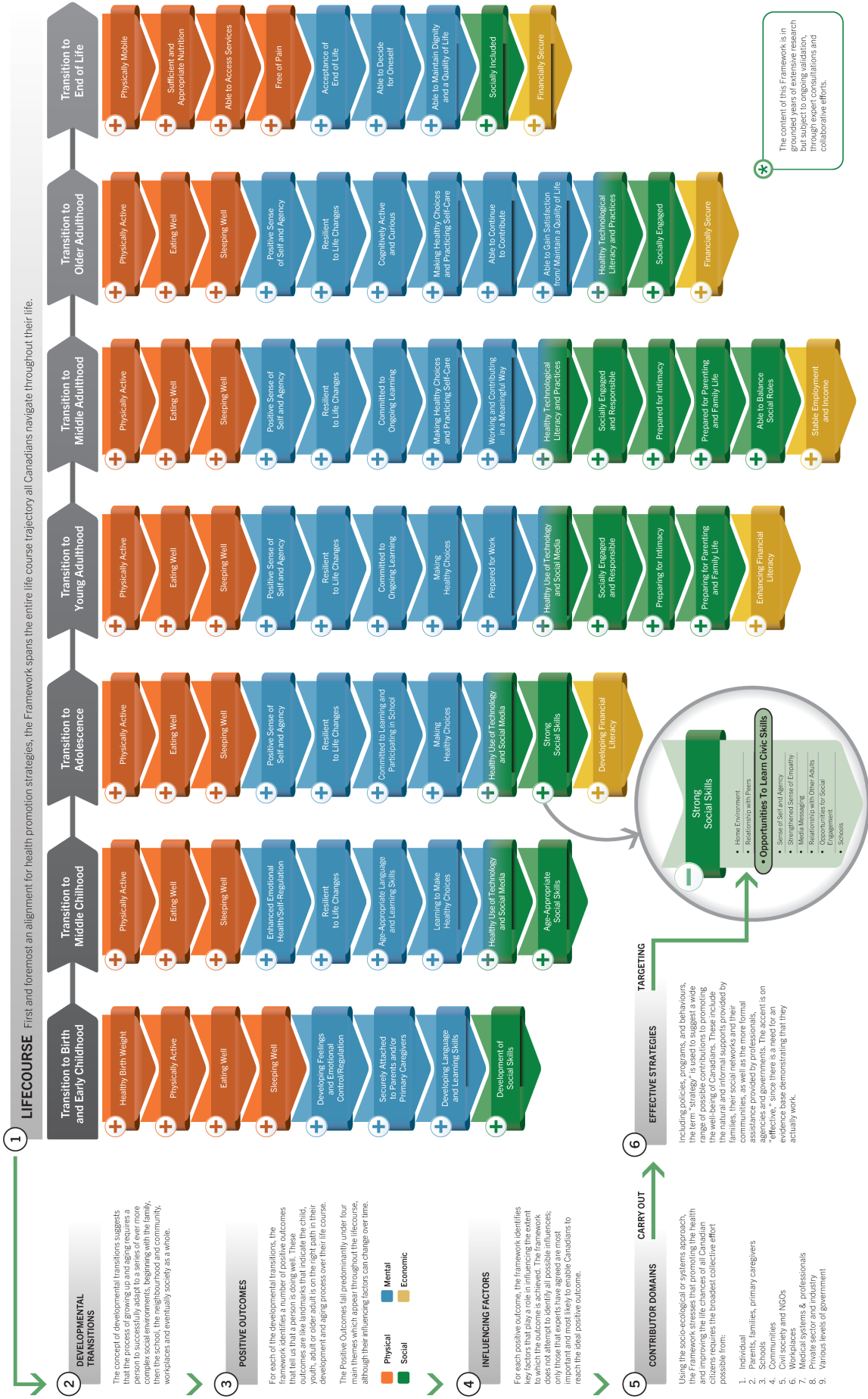
### Graphic illustration of the Health Promotion Alignment Framework

What follows is a visual representation of the Health Promotion Alignment Framework. It summarises the Framework's six core components and illustrates how they work together to align action across jurisdictions, sectors, and contributor domains.

The Framework is structured around the following key elements, numbered accordingly in the graphic illustration below.

1. **Life course** — A focus on the entire life course, recognising that health is not static but evolves across different stages of life.
2. **Developmental transitions** — A structuring of the life course around key transitions, recognising that individuals navigate through increasingly complex social environments as they grow, play, learn, work, age, and contribute to society.
3. **Positive outcomes** — A focus on the achievement of positive health outcomes as measurable indicators, shifting from a deficit-based model centred mainly on disease prevention toward a more proactive orientation to well-being, resilience, and healthy development.
4. **Influencing factors** — A breakdown of each positive outcome into the key factors and conditions that shape a person's ability to achieve it.
5. **Contributor domains** — The recognition that all sectors contribute to health, reinforcing that health promotion is not the sole responsibility of governments or medical systems but requires engagement across multiple socio-ecological domains.
6. **Effective strategies** — A structured inventory of evidence-based strategies that helps ensure that action, policy, programme, and institutional decisions are grounded in credible and actionable approaches rather than broad conceptual intent or popular but unproven interventions. These strategies answer a practical question: what can each contributor domain do?

# THE HEALTH PROMOTION ALIGNMENT FRAMEWORK



## APPENDIX C

### List of positive outcomes and their influencing factors

The effectiveness of health promotion efforts, whether expressed through policy, programmes, institutional practice, or supported behaviour change, depends on their ability to help achieve measurable, positive outcomes across the life course. The following list presents a structured set of positive health outcomes and their main influencing factors, that is, the conditions that most shape a person's ability to achieve a given outcome. Developed over more than a decade through multidisciplinary research and expert consultation, these outcomes and influencing factors are grouped, for practical purposes, under four broad themes: physical, mental, social, and economic.

While the graphic illustration in Appendix B presents the positive outcomes visually, space constraints prevent the inclusion of their main influencing factors. They are therefore listed here for reference.

While this list is grounded in extensive research and expert consultation, it should not be treated as culturally neutral or permanently settled in every respect. Social conditions, institutional realities, cultural expectations, and technological environments vary across settings and continue to evolve over time. For that reason, the contextual relevance, prioritisation, and application of these outcomes and influencing factors should continue to be strengthened through structured engagement processes, including expert consultation, roundtables, and other collaborative validation mechanisms.

This does not mean that the Framework's core architecture is endlessly negotiable. Rather, it means that the practical interpretation, emphasis, and application of particular outcomes, influencing factors, and strategies may require contextual refinement across jurisdictions, populations, and institutional settings.

By maintaining a commitment to collaborative implementation, open-by-default knowledge-sharing, shared measurement where appropriate, and ongoing refinement, jurisdictions and institutions can help ensure that health promotion remains a sustained and evolving field of practice rather than a static policy framework.

Sustained engagement, including co-developed strategies, shared learning mechanisms, and continuing policy dialogue, will remain important both to implementation success and to long-term institutional durability.

## Transition 1 – To Birth & Early Childhood

(BEFORE BIRTH TO +/- AGE 1)

	POSITIVE OUTCOMES	INFLUENCING FACTORS
<b>PHYSICAL</b>	<b>Healthy prenatal development &amp; birth weight</b>	<ul style="list-style-type: none"> <li>• Maternal Nutrition</li> <li>• Exposure to Toxins &amp; Environmental Risks</li> <li>• Maternal Stress &amp; Emotional Well-being</li> <li>• Parental Knowledge &amp; Practices</li> </ul>
	<b>Physically Active</b>	<ul style="list-style-type: none"> <li>• Access to and Opportunities for Informal Play</li> <li>• Healthy and Supportive Physical Environments</li> </ul>
	<b>Eating Well</b>	<ul style="list-style-type: none"> <li>• Access to Healthy and Nutritious Foods</li> <li>• Parents' Knowledge, Beliefs, Expectations and Practices</li> </ul>
	<b>Sleeping Well</b>	<ul style="list-style-type: none"> <li>• Supportive Physical Environment</li> <li>• Parents' Knowledge, Beliefs, Expectations and Practices</li> </ul>
<b>MENTAL</b>	<b>Developing Feelings and Emotional Control/Regulation</b>	<ul style="list-style-type: none"> <li>• Emerging Sense of Competence</li> <li>• Supportive Social Environments</li> <li>• Sensitive attunement and Responsiveness of Parents</li> <li>• Infant's Temperament</li> </ul>
	<b>Securely Attached to Parents and/or Primary Caregivers</b>	<ul style="list-style-type: none"> <li>• Sensitive Attunement of Parents</li> <li>• Emotional Health of Parents</li> <li>• Parents' Knowledge, Beliefs, Expectations and Practices</li> </ul>
	<b>Developing Language and Learning Skills</b>	<ul style="list-style-type: none"> <li>• Quality Early Child Care and Pre-School Education</li> <li>• Parents' Knowledge, Beliefs, Expectations and Practices</li> <li>• Stimulating Homes</li> </ul>
<b>SOCIAL</b>	<b>Development of Social Skills</b>	<ul style="list-style-type: none"> <li>• Relationship with Parents and/or Primary Caregivers</li> <li>• Relationship with Peers</li> </ul>

## Transition 2 – To Early Childhood

(BEFORE +/- AGE 5)

	POSITIVE OUTCOMES	INFLUENCING FACTORS
<b>PHYSICAL</b>	<b>Physically Active</b>	<ul style="list-style-type: none"> <li>• Access to and Opportunities for Informal Play</li> <li>• Healthy and Supportive Physical Environments</li> <li>• Parents’ beliefs, expectations and practices</li> <li>• Media Messaging</li> </ul>
	<b>Eating Well</b>	<ul style="list-style-type: none"> <li>• Access to Healthy and Nutritious Foods</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• One’s Own Knowledge, Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> </ul>
	<b>Sleeping Well</b>	<ul style="list-style-type: none"> <li>• Supportive Physical Environment</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• Healthy, Supportive Family Environment</li> <li>• Child’s Temperament</li> </ul>
<b>MENTAL</b>	<b>Enhanced Emotional Health / Self-Regulation</b>	<ul style="list-style-type: none"> <li>• Emerging Sense of Competence</li> <li>• Safe, Secure and Supportive Social Networks (incl. parents)</li> <li>• Secure Attachment to Parents and/or Primary Caregivers</li> <li>• Infant’s Temperament</li> </ul>
	<b>Resilient to Life Changes</b>	<ul style="list-style-type: none"> <li>• Secure Attachment to Parent and/or Primary Caregivers</li> <li>• Relationship with Peers</li> <li>• Optimism</li> <li>• Sensitive Attunement of Parents</li> <li>• Emotional Health of Parents</li> </ul>
	<b>Age-Appropriate Language and Learning Skills</b>	<ul style="list-style-type: none"> <li>• Quality, Inclusive Early Child Care and Pre-School Edu</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• Stimulating Homes</li> </ul>
	<b>Learning to Make Healthy Choices</b>	<ul style="list-style-type: none"> <li>• Emerging Sense of Self &amp; Age</li> <li>• Supportive Physical Environment</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> </ul>
<b>SOCIAL</b>	<b>Age-Appropriate Social Skills</b>	<ul style="list-style-type: none"> <li>• Relationship with Parents and/or Primary Caregivers</li> <li>• Relationship with Peers</li> <li>• Development of Sense of Empathy</li> <li>• Relationship with Other Adults</li> </ul>

## Transition 3 – To Adolescence

(BEFORE +/- AGE 12)

	POSITIVE OUTCOMES	INFLUENCING FACTORS
<b>PHYSICAL</b>	<b>Physically Active</b>	<ul style="list-style-type: none"> <li>• Access to and Opportunities for Informal Play</li> <li>• Healthy and Supportive Physical Environments</li> <li>• Parents’ and One’s Own beliefs, expectations and practices</li> <li>• Media Messaging</li> <li>• Access to and Opportunities for Formal Exercise</li> <li>• Ability to Make Own Decisions</li> </ul>
	<b>Eating Well</b>	<ul style="list-style-type: none"> <li>• Access to Healthy and Nutritious Foods</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• One’s Own Knowledge, Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> </ul>
	<b>Sleeping Well</b>	<ul style="list-style-type: none"> <li>• Supportive Physical Environment</li> <li>• Emotional Health and Resilience</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• Healthy, Supportive Family Environment</li> <li>• Relationship with Peers</li> <li>• Child’s Temperament</li> </ul>
<b>MENTAL</b>	<b>Positive Sense of Self and Agency</b>	<ul style="list-style-type: none"> <li>• Strengthened Sense of Competence</li> <li>• Safe, Secure and Supportive Social Networks (incl. parents)</li> <li>• Secure Attachment to Parents and/or Primary Caregivers</li> <li>• Self-Identity</li> <li>• Media Messaging</li> </ul>
	<b>Resilient to Life Changes</b>	<ul style="list-style-type: none"> <li>• Relationship with Parents and Significant Others</li> <li>• Relationship with Peers</li> <li>• Optimism</li> <li>• Sense of Self and Agency</li> <li>• Prepared Schools</li> </ul>
	<b>Committed to Learning and Participating in School</b>	<ul style="list-style-type: none"> <li>• Supportive School Environment</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• Sense of Self and Agency</li> <li>• Relationship with Peers</li> <li>• Strong Social Skills</li> <li>• Opportunities to Engage in School Activities</li> </ul>
	<b>Making Healthy Choices</b>	<ul style="list-style-type: none"> <li>• Strengthened Sense Self &amp; Agency</li> <li>• Supportive Physical Environments</li> <li>• Emergence of Health Literacy</li> <li>• Emergence of Financial Literacy</li> <li>• Resiliency</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• Peers and Significant Others</li> </ul>
<b>SOCIAL</b>	<b>Strong Social Skills</b>	<ul style="list-style-type: none"> <li>• Home Environments</li> <li>• Relationship with Peers</li> <li>• Sense of Self and Agency</li> <li>• Strengthened Sense of Empathy</li> <li>• Media Messaging</li> <li>• Relationship with Other Adults</li> <li>• Opportunities for Social Engagement</li> <li>• Schools and Opportunities To Learn Civic Skills</li> </ul>

## Transition 3 – To Adolescence

(BEFORE +/- AGE 12)

<b>MENTAL/ SOCIAL</b>	<b>Healthy Use of Technology and Social Media</b>	<ul style="list-style-type: none"> <li>• Parental guidance and digital literacy</li> <li>• Access to age-appropriate content and safety measures</li> <li>• Peer influences and social norms</li> <li>• Media literacy and critical thinking skills</li> <li>• Balanced screen time and offline activities</li> <li>• Awareness of social media’s impact on mental health and self-perception</li> </ul>
<b>ECONOMIC</b>	<b>Developing Financial Literacy</b>	<ul style="list-style-type: none"> <li>• Parental attitudes and role modeling of financial habits</li> <li>• Early exposure to basic money management (allowance, savings)</li> <li>• School-based financial education programmes</li> <li>• Opportunities to practice financial decision-making</li> <li>• Digital influences (advertising, in-app purchases, social media pressures)</li> </ul>

## Transition 4 – To Young Adulthood

(BEFORE +/- AGE 20)

	POSITIVE OUTCOMES	INFLUENCING FACTORS
<b>PHYSICAL</b>	<b>Physically Active</b>	<ul style="list-style-type: none"> <li>• Sense of Body Image</li> <li>• Healthy and Supportive Physical Environment</li> <li>• Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> <li>• Access to and Opportunities for Formal Exercise</li> <li>• Ability to Make Own Decisions</li> </ul>
	<b>Eating Well</b>	<ul style="list-style-type: none"> <li>• Access to Healthy and Nutritious Foods</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• One’s Own Knowledge, Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> </ul>
	<b>Sleeping Well</b>	<ul style="list-style-type: none"> <li>• Supportive Physical Environment</li> <li>• Emotional Health and Resilience</li> <li>• Healthy, Supportive Family Environment</li> <li>• Relationship with Peers</li> <li>• Academic Environment and Achievement</li> </ul>
<b>MENTAL</b>	<b>Positive Sense of Self and Agency</b>	<ul style="list-style-type: none"> <li>• Sense of Competence</li> <li>• Safe, Secure and Supportive Social Networks</li> <li>• Self-Identity</li> <li>• Media Messaging</li> </ul>
	<b>Resilient to Life Changes</b>	<ul style="list-style-type: none"> <li>• Relationship with Parents and Significant Others</li> <li>• Relationship with Peers</li> <li>• Optimism</li> <li>• Sense of Self and Agency</li> </ul>
	<b>Committed to Ongoing Learning</b>	<ul style="list-style-type: none"> <li>• Supportive School Environment</li> <li>• Sense of Self and Agency</li> <li>• Relationship with Peers</li> <li>• Strong Social Skills</li> <li>• Opportunities to Engage in School Activities</li> <li>• Opportunities to Work and Learn Work-Related Skills</li> <li>• Past Academic Achievement (?)</li> </ul>
	<b>Making Healthy Choices</b>	<ul style="list-style-type: none"> <li>• Strengthened Sense Self &amp; Agency</li> <li>• Supportive Physical Environments</li> <li>• Health Literacy</li> <li>• Strengthened Financial Literacy</li> <li>• Resiliency</li> <li>• Parents’ Knowledge, Beliefs, Expectations and Practices</li> <li>• Peers and Significant Others</li> </ul>
	<b>Prepared for Work</b>	<ul style="list-style-type: none"> <li>• Formal Educational Achievement</li> <li>• Opportunities to Work and Learn Work-Related Skills</li> <li>• Strong Sense of Self and Agency</li> </ul>
<b>MENTAL/ SOCIAL</b>	<b>Healthy Use of Technology and Social Media</b>	<ul style="list-style-type: none"> <li>• Self-regulation and time management skills</li> <li>• Understanding of data privacy</li> <li>• Awareness of social media’s impact on mental health and self-perception</li> <li>• Critical thinking and ability to discern misinformation</li> <li>• Healthy balance between online engagement and real-world connections</li> </ul>
<b>SOCIAL</b>	<b>Socially Engaged and Responsible</b>	<ul style="list-style-type: none"> <li>• Family Culture</li> <li>• Relationship with Peers</li> <li>• Sense of Self and Agency</li> <li>• Sense of Empathy</li> <li>• Media Messaging</li> <li>• Opportunities to Make Meaningful Contributions</li> <li>• Schools and Opportunities To Learn Civic Skills</li> </ul>

## Transition 4 – To Young Adulthood

(BEFORE +/- AGE 20)

### Preparing for Intimacy

- Family Culture
- Sense of Self and Agency
- Positive Relationships
- Gender and Role Socialization
- Societal, Cultural and Religious Influences
- Media Messaging

### Preparing for Parenting and Family Life

- Exposure to positive role models in family life
- Sex education and understanding of reproductive health
- Emotional maturity and relationship-building skills
- Financial and housing stability
- Cultural and societal expectations around parenting

### **ECONOMIC** Enhancing Financial Literacy

- Access to financial education and tools (apps, workshops)
- Experience managing personal finances (student loans, credit cards)
- Understanding of financial planning
- Economic stability and employment opportunities
- Awareness of financial risks (debt, scams, predatory lending)

## Transition 5 – To Middle Adulthood

(BEFORE +/- AGE 40)

	POSITIVE OUTCOMES	INFLUENCING FACTORS
<b>PHYSICAL</b>	<b>Physically Active</b>	<ul style="list-style-type: none"> <li>• Sense of Body Image and Pride/Dignity</li> <li>• Healthy and Supportive Physical Environment</li> <li>• Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> <li>• Time Management and Balancing Social Roles</li> </ul>
	<b>Eating Well</b>	<ul style="list-style-type: none"> <li>• Access to Healthy and Nutritious Foods</li> <li>• One's Own Knowledge, Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> <li>• Time Management and Balancing Social Roles</li> </ul>
	<b>Sleeping Well</b>	<ul style="list-style-type: none"> <li>• Supportive Physical Environment</li> <li>• Emotional Health and Resilience</li> <li>• Physical Health</li> <li>• Ability to Balance Social Roles</li> </ul>
<b>MENTAL</b>	<b>Positive Sense of Self and Agency</b>	<ul style="list-style-type: none"> <li>• Sense of Competence</li> <li>• Safe, Secure and Supportive Social Networks</li> <li>• Self-Identity</li> <li>• Media Messaging</li> </ul>
	<b>Resilient to Life Changes</b>	<ul style="list-style-type: none"> <li>• Healthy, Supportive Family Environment</li> <li>• Relationship with Peers</li> <li>• Optimism</li> <li>• Sense of Self and Agency</li> </ul>
	<b>Committed to Ongoing Learning</b>	<ul style="list-style-type: none"> <li>• Sense of Self and Agency</li> <li>• Relationship with Peers</li> <li>• Strong Social Skills</li> <li>• Opportunities to Engage in Learning Activities &amp; Adult Education</li> <li>• Opportunities to Work and Learn Work-Related Skills</li> <li>• Past Academic Achievement</li> <li>• Able to Balance Social Roles</li> </ul>
	<b>Making Healthy Choices and Practicing Self-Care</b>	<ul style="list-style-type: none"> <li>• Strengthened Sense Self &amp; Agency</li> <li>• Supportive Physical Environments</li> <li>• Health Literacy</li> <li>• Financial Literacy</li> <li>• Resiliency</li> <li>• Peers and Significant Others</li> <li>• Able to Balance Social Roles</li> </ul>
	<b>Working and Contributing in a Meaningful Way</b>	<ul style="list-style-type: none"> <li>• Career stability and job satisfaction</li> <li>• Skills development and lifelong learning opportunities</li> <li>• Supportive work environments and professional networks</li> <li>• Economic conditions and job market trends</li> <li>• Balance between work, family, and personal well-being</li> </ul>
<b>MENTAL/ SOCIAL</b>	<b>Healthy Technological Literacy and Practices</b>	<ul style="list-style-type: none"> <li>• Ongoing adaptation to evolving digital tools and platforms</li> <li>• Digital privacy awareness and cybersecurity practices</li> <li>• Ability to critically assess online information</li> <li>• Use of technology for professional growth and efficiency</li> <li>• Maintaining healthy digital boundaries (e.g., work-life balance)</li> </ul>
<b>SOCIAL</b>	<b>Socially Engaged and Responsible</b>	<ul style="list-style-type: none"> <li>• Relationship with Peers</li> <li>• Sense of Self and Agency</li> <li>• Sense of Empathy</li> <li>• Schools and Opportunities To Learn Civic Skills</li> <li>• Opportunity to Balance Social Roles</li> </ul>
	<b>Prepared for Intimacy</b>	<ul style="list-style-type: none"> <li>• Family Culture</li> <li>• Sense of Self and Agency</li> <li>• Positive Relationships</li> <li>• Gender and Role Socialization</li> <li>• Societal, Cultural and Religious Influences</li> <li>• Media Messaging</li> </ul>

## Transition 5 – To Middle Adulthood

(BEFORE +/- AGE 40)

### Prepared for Parenting and Family Life

- Work-life balance and parental leave policies
- Access to childcare and family support systems
- Financial stability and long-term planning
- Emotional readiness and parenting confidence
- Social and cultural expectations of parenting

### Able to Balance Social Roles

- Sense of Self and Agency
- Workplace Flexibility & Job Security
- Family Structure & Expectations
- Social Support Networks
- Personal Time Management & Coping Strategies

### **ECONOMIC** Stable Employment and Income

- Job market trends and economic stability
- Access to continuing education and career development
- Employer benefits and protections
- Workplace policies on equity and inclusivity
- Geographic mobility and housing affordability

## Transition 6 – To Older Adulthood

(BEFORE +/- AGE 85)

	POSITIVE OUTCOMES	INFLUENCING FACTORS
<b>PHYSICAL</b>	<b>Physically Active</b>	<ul style="list-style-type: none"> <li>• Sense of Body Image and Pride/Dignity</li> <li>• Healthy and Supportive Physical Environment</li> <li>• Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> <li>• Desire to Remain Physically Mobile and Functionally Independent</li> </ul>
	<b>Eating Well</b>	<ul style="list-style-type: none"> <li>• Access to Healthy and Nutritious Foods</li> <li>• One's Own Knowledge, Beliefs, Expectations and Practices</li> <li>• Media Messaging</li> </ul>
	<b>Sleeping Well</b>	<ul style="list-style-type: none"> <li>• Supportive Physical Environment</li> <li>• Emotional Health and Resilience</li> <li>• Physical Health</li> </ul>
<b>MENTAL</b>	<b>Positive Sense of Self and Agency</b>	<ul style="list-style-type: none"> <li>• Sense of Competence</li> <li>• Safe, Secure and Supportive Social Networks</li> <li>• Self-Identity</li> <li>• Media Messaging</li> </ul>
	<b>Resilient to Life Changes</b>	<ul style="list-style-type: none"> <li>• Healthy, Supportive Family Environment</li> <li>• Optimism</li> </ul>
	<b>Cognitively Active and Curious</b>	<ul style="list-style-type: none"> <li>• Sense of Self and Agency</li> <li>• Relationship with Peers</li> <li>• Strong Social Skills</li> <li>• Opportunities to Engage in Learning Activities &amp; Adult Educ.</li> <li>• Opportunities for Contributions</li> </ul>
	<b>Making Healthy Choices and Practicing Self-Care</b>	<ul style="list-style-type: none"> <li>• Strengthened Sense Self &amp; Agency</li> <li>• Supportive Physical Environments</li> <li>• Health Literacy</li> <li>• Financial Literacy</li> <li>• Resiliency</li> <li>• Peers and Significant Others</li> </ul>
	<b>Able to Continue to Contribute</b>	<ul style="list-style-type: none"> <li>• Societal Attitudes on Ageism</li> <li>• Opportunities to Engage in Volunteer and Other Activities</li> <li>• Strong Sense of Self and Agency</li> </ul>
<b>MENTAL/ SOCIAL</b>	<b>Healthy Technological Literacy and Practices</b>	<ul style="list-style-type: none"> <li>• Access to user-friendly technology and digital training programmes</li> <li>• Cognitive adaptability to evolving digital landscapes</li> <li>• Cybersecurity awareness and fraud prevention</li> <li>• Social engagement through digital platforms</li> <li>• Use of technology to support health and independence</li> </ul>
<b>SOCIAL</b>	<b>Socially Engaged</b>	<ul style="list-style-type: none"> <li>• Sense of Self and Agency</li> <li>• Strong personal relationships and community involvement</li> <li>• Accessible social networks and support groups</li> <li>• Opportunities for mentorship and knowledge-sharing</li> <li>• Age-friendly environments that encourage participation</li> <li>• Mental and physical well-being enabling engagement</li> </ul>
<b>ECONOMIC</b>	<b>Financially Secure</b>	<ul style="list-style-type: none"> <li>• Retirement savings and pension plans</li> <li>• Financial literacy and planning throughout life</li> <li>• Affordable housing and healthcare access</li> <li>• Government support and social security programmes</li> <li>• Protection against financial exploitation and fraud</li> </ul>

## Transition 7 – To End of Life

(BEFORE +/- AGE 85)

	OUTCOME	INFLUENCING FACTORS
<b>PHYSICAL</b>	<b>Physically Mobile</b>	<ul style="list-style-type: none"> <li>Physical Environment</li> <li>Access to equipment</li> <li>Supportive Caregiving &amp; Social Assistance</li> </ul>
	<b>Sufficient and Appropriate Nutrition</b>	<ul style="list-style-type: none"> <li>Access to Healthy and Nutritious Foods</li> <li>Ability to Eat Independently or With Assistance</li> <li>Supportive Care or Meal Services</li> </ul>
	<b>Able to Access Services</b>	<ul style="list-style-type: none"> <li>Availability and affordability of healthcare and social services</li> <li>Mobility and transportation options</li> <li>Clear guidance on navigating the healthcare system</li> <li>Digital accessibility of services for aging populations</li> <li>Family and caregiver support networks</li> </ul>
	<b>Free of Pain</b>	<ul style="list-style-type: none"> <li>Access to appropriate pain management and palliative care</li> <li>Emotional and psychological support services</li> <li>Cultural and personal preferences in end-of-life care</li> </ul>
<b>MENTAL</b>	<b>Acceptance of End of Life</b>	<ul style="list-style-type: none"> <li>Optimism</li> <li>Emotional and Spiritual Support</li> <li>Social Connection &amp; Support Networks</li> </ul>
	<b>Able to Decide for Oneself</b>	<ul style="list-style-type: none"> <li>Strong Sense of Self &amp; Agency</li> <li>Health Literacy</li> <li>Access to Advanced Care Planning</li> <li>Cognitive Capacity &amp; Mental Clarity</li> </ul>
	<b>Able to Maintain Dignity and a Quality of Life</b>	<ul style="list-style-type: none"> <li>Autonomy and involvement in decision-making</li> <li>Access to home care and assisted living options</li> <li>Support for mental and emotional well-being</li> <li>Social and community inclusion</li> <li>Respect for personal values, traditions, and end-of-life wishes</li> </ul>
<b>SOCIAL</b>	<b>Socially Included</b>	<ul style="list-style-type: none"> <li>Relationship with Family, Caregivers and Significant Others</li> <li>Opportunities to participate in decisions</li> </ul>
<b>ECONOMIC</b>	<b>Financially Secure</b>	<ul style="list-style-type: none"> <li>Retirement income and savings</li> <li>Long-term care and housing options</li> <li>Estate planning and financial protections</li> <li>Awareness of financial fraud targeting seniors</li> <li>Support for caregivers and family financial stability</li> </ul>

## About the author

Marc Dupont is a policy strategist and framework architect whose work spans the public, private, and non-profit sectors. He works at the intersection of strategy, governance, organisational transformation, leadership development, and health promotion, with a particular focus on helping institutions navigate complexity, align systems and people, and translate ambitious ideas into measurable outcomes.

Marc's work has included advising Canada's Federal House of Commons Standing Committee on Health, contributing to Canada's response to the UN Framework Convention on Tobacco Control, and leading major pan-Canadian policy and consultation initiatives. Earlier in his career, he co-founded and led a renowned health consulting firm responsible for more than 500 strategic planning, governance, evaluation, facilitation, and organisational development projects across public, non-profit, and community settings.

He later spent two decades in senior leadership and advisory roles within the Government of Canada, working across public health, health promotion, digital transformation, service modernisation, organisational change, enterprise governance, executive learning, and performance and talent management.

The Health Promotion Alignment Framework, which Marc developed through decades of work in public policy, health promotion, organisational development, strategic planning, and executive leadership, reflects his long-standing interest in positive outcomes, systems alignment, and the practical challenge of turning broad policy recognition into durable institutional action.

For inquiries related to the Health Promotion Alignment Framework or related materials, he can be reached through [www.lacmeechstrategies.com](http://www.lacmeechstrategies.com) or at [marcdupont@lacmeech.com](mailto:marcdupont@lacmeech.com)