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# Developing a competent global health promotion workforce: pedagogy and practice.

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# Table of Contents

## Setting the Scene: Improving Health in a Globalising World

We are living through a period of rapid globalisation, where related processes; political, social and economic, are increasingly impacting upon the health of the world's population, often as a result of widespread health inequalities. The complexity of these global phenomena combined with associated health determinants, constitute key indicators in defining health outcomes (Gugglberger and Hall, 2014).

Global approaches and inter-sectoral collaborative efforts are required more than ever, particularly in ensuring robustness of structures related to health promotion and public health, which can respond to global health challenges and work towards improving health outcomes at international, national and local levels. A key aspect of this challenge is ensuring a competent workforce is in place to tackle these challenges and to empower citizens as collaborators within this process. However, social, political and economic diversity across and within countries has increased disparity within the professional workforce capacity, to use common approaches to tackle the determinants of health and to improve health outcomes. Furthermore, the global financial crisis and resultant austerity measures has meant that the remit of the professional workforce has become broader in recognition of the meaning and the origins of health, in its broadest sense.

This discussion paper responds to and tackles these issues by examining concepts and principles inherent within health promotion, exploring the issues around developing a competent health promotion workforce using appropriate pedagogical strategies to facilitate this process. Education and training approaches which draw upon core values inherent within the health promotion paradigm are presented and discussed. Examples are given of models of pedagogical practice which could be useful not only within education institutions, but also within the workplace as effective strategies for enhancing professional development. Recommendations are made for moving this discussion forward and for developing capacity through increased professional competence within the global health promotion workforce.

## Health promotion: Concepts and Values

Health promotion emerged and has been evolving as a discipline over the past 3 decades. In defining health promotion, debates have ensued as to its existence as a discipline in its own right, or as an umbrella term which covers the activities of a number of disciplines (Tones and Green, 2004), including sociology, psychology, education, epidemiology, and with minor contributions from communications, social policy, marketing, politics and ethics (Bunton and Macdonald, 1992, 2002). In defining parameters for their existence, each discipline draws upon a different knowledge base (Naidoo and Wills, 1999) within which competing ideologies have added fuel to debate. The context for debate has been a marked shift from an individualistic behavioural approach, commonly aligned to the positivist bio-medical perspective, to one in which health is understood in its broadest sense, as a holistic concept, and which reflects the (health producing) salutogenic perspective (Antonovsky, 1987, 1993) which emphasises keeping people healthy, and where health is viewed on a continuum (Katz et al, 2002).

Some of the distinctive and distinguishing features of the discipline of health promotion stem from its political roots, its alignment with the 'new public health' and its emergence as a social movement (Bunton and Macdonald, 1992, 2002). Inherent within the concept of health promotion are its strong underpinning principles, values and ethos. The World Health Organisation (WHO) (European office) articulated these concepts and principles for the first time within a specific programme of work (WHO, 1984), following which WHO led a series of international conferences, each of which produced statements which reinforced the global vision for health promotion policy and practice and its values base and proposed strategies for action at a global level, which would impact at international, national and local levels (WHO, 2009).

The inaugural WHO health promotion conference in Ottawa was arguably the most significant milestone in the history of health promotion as before then, few efforts had been made to seek consensus on the definition of health promotion (Macdonald, 1998). It was here that the conceptual framework for health promotion was established and action areas explained (WHO, 1986). The Charter described health promotion as *"the process of enabling individuals and communities to increase control over, and to improve their health" (*WHO 1986) and outlined the principles of health promotion out as being to advocate, enable and to mediate. The action areas were set as: to build healthy public policy, to create supportive environments, to strengthen community actions, to develop personal skills and to reorient health services. Values inherent within the vision of the Ottawa charter were based on the Health for All principles, as adopted in 1977 by the World Health Organisation (WHO, 1977) and as outlined within the Global Strategy for Health for All by the year 2000 (WHO, 1981); social justice, equity, empowerment and self-determination.

The definition of health promotion and its place as a distinctive discipline will no doubt continue to be contested within the academic community, however, the underlying concepts, principles and values continue to strengthen and to underpin and to guide health promotion policy and practices today and to act as a guide to the health promotion workforce at a global level.

## Health Promotion Competencies: An International Review

Attempts have been made globally to define competencies, although consensus has not been reached as to its concise meaning, with subtle differences definitions proposed, which reflect the context for and use of the term. Competence has been defined as the "state or quality of being adequately or well qualified" or indeed "a specific range of skill, knowledge or ability" (www.thefreedictionary.com, n.d.). The meaning of competence reflects a capacity to act effectively within a defined situation, supported by knowledge, but not limited to them (Perrenoud, 1995) and within the United Kingdom, functional competence has been encapsulated within a definition which refers to the ability to use knowledge, understanding and practical thinking skills to perform effectively to the national standards (Griffiths and Dark, 2005). Furthermore, within the educational context, it has been defined as a

combination of knowledge, skills and attitudes conducive to give an adequate performance in a given field (Irgoin and Vargas, 2002).

The use and influence of the term competence has increased in past decades, first, rising to popularity within business organisations for recruitment and selection purposes as a predictor of successful work performance (McClelland, 1973) and as an employee performance assessment tool (Spencer and Spencer, 1993). The emergence of competence has also made an impact in education, wherein the competence-based education movement shifted the emphasis from what should be taught (knowledge acquisition,) to what the graduate should be competent to do (output side) (Harris et al, 1995).

The relevance of competencies to the field of health promotion can thus be attributed both to the development of the workforce in terms of knowledge, skills and abilities to perform functions effectively, as well as the potential to build capacity within the workforce through education, training and mentoring in order to optimise their competence. Furthermore, in relating the issue of competence to the specificities implied by and inherent within different professional disciplines, core competencies have become increasingly relevant. Core competencies can be defined as the "minimum set of competencies that constitute a common baseline for all health promotion roles" (Dempsey et al, 2011, p15) and are "what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field" (Australian Health Promotion Association, 2009, p2).

There have been a number of reviews conducted of health promotion competencies and the related discipline of public health and associated competencies, in different regions across the world (Health Promotion Forum of New Zealand, 2004; Public Health Association of Canada, 2007; Shilton et al., 2008; Melville et al, 2006) and consensus has been reached concerning general competencies in the fields of health promotion and public health (ASPHER, 2008; Kosa and Stock, 2006, Meresman et al, 2006). Increased momentum over the last decade within Europe has seen a shifting emphasis towards the establishment of core competencies for health promotion, and a number of European projects were funded by the European Commission to develop this work including the EUMAHP Projects PHASE 1 and 2 (Davies et al, 2000, 2004); the PHETICE project (Davies et al, 2008) and more recently, the CompHP project (Barry et al, 2012).

Whilst these projects were based in Europe, they relied on international literature as well as advisors within their steering committees and in order to maintain the broadest perspective to their work. As a result of this concentrated period of activity concerning developing core competencies, and as a result of recent efforts within the CompHP project, international consensus has now been reached on core competencies for health promotion. The International Union for Health Promotion and Education (IUHPE) is now instrumental in taking forward this work within a dedicated global working group on competencies and workforce development. This programme of work complements and adds to the competency-development work that is being carried out in other parts of the world, such as the recent review of Health Promotion Competencies for Aotearoa New Zealand (Health Promotion Forum of New Zealand (2012). There are strong overlaps between the competencies

frameworks developed in Europe and New Zealand; both are underpinned by ethical foundations and reflect the principles outlined within the Ottawa Charter (WHO, 1986), globally accepted as integral to health promotion. In addition, both subscribe to a health promotion knowledge base as guiding practice, as detailed within other core domains/clusters. These domains/clusters include: enable change, advocate, mediate, communicate, lead, assess, plan, implement, evaluate and research. Within each domain/cluster, defined skills are recognised as goals in demonstrating competence within each area. The main apparent difference between the European model and that of New Zealand is the explicit recognition, within the latter, of the special relationship with Maori, the Indigenous peoples of New Zealand, and Te Tiriti o Waitangi, the 1840 treaty between the British Crown and Maori. This treaty is widely accepted as the founding constitutional document of New Zealand and is the basis of the key relationship between New Zealand's original people and the British Crown, now represented by the New Zealand Government. The signing of Te Tiriti itself is, at least in part, premised on a wider concern for Maori health at the time and when applied in a contemporary context continues to be a very useful framework for Maori health development (Kingi, 2007). Given the existing inequities in health between Maori and Non-Maori there is a strong argument that the Tiriti relationship necessitates an increased focus on Maori health outcomes- both from a moral and legal standpoint but also from an economic and social perspective. The competencies identified define the behaviour, skills, knowledge and attitudes needed by health promoters to work effectively and appropriately with Maori and other people, communities, and organisations in Aotearoa New Zealand (Adapted from Health and Disability Advocacy Nga Kaitautoko, 2006). This demonstrates a stronger emphasis on culture, and the relationship to workforce competence, than is seen within the European context and recent related work programme. New Zealand is particularly progressive in this regard and could offer guidance to Europe (and globally), for integrating these aspects into the recently-produced competence model. Inevitably, this approach would bring challenges to culturally diverse communities, across Europe and more widely across the world. Adaptability and flexibility of any proposed competence model could be a way of integrating culture in a sensitive way, which allows for appreciation of diversity across nations. A key question remains; should cultural competence be integrated into the value set and knowledge base which underpins the work of a health promoter, or does this deserve a competence-specific domain in its own right?

What can we learn from the international work developing health promotion competencies and how can this be taken forward into the institutions and organisations, tasked with equipping the future health promotion workforce, in order to demonstrate knowledge and present evidence, through practice of their competence as a health promoter? In order to address this question, we can look to the area of capacity building through training and education.

## Capacity Building the Health Promotion workforce

Rapid innovation in global approaches to policy, healthcare and research may be attributed to increased recognition that health determinants provide key indicators in defining health outcomes. In addition globalisation processes, including international and political

integration, mean a greater need for a workforce (including academics, practitioners and policy makers) competent to work across different cultures and settings and adopt a transnational perspective (de Rosa, 2008). These processes have created demand for high quality and internationally trained professionals in the field of health promotion and its related disciplines (Gugglberger and Hall, 2014). The WHO Commission on Social Determinants of Health was set up in 2005 to review evidence on promoting global health equity. With the social justice agenda at its core, the Commission has called on governments, civil society, WHO and other global organisations to make efforts to use global approaches to promote health equity through tackling social determinants of health (WHO, 2008). Recent efforts have been made to examine power disparities and dynamics across policy areas that intersect the health agenda and which need improved global governance, by the Commission on Global Governance for Health (University of Oslo, 2014).

As a 'unique discipline' (Davies, 2014), health promotion requires distinct approaches and a well-trained, competent workforce in order to work effectively in daily practices. The substantial developments in the area of health promotion competencies have challenged and 'raised the bar' for health promotion training and education programmes to respond and to produce and deliver high quality programmes of study which facilitate success in producing a skilled and competent health promotion workforce. Other factors driving the need for capacity building a global health promotion workforce include: increased mobility of students, a rise in funded programmes which encourage and support students to be more mobile, the high value placed upon considering global perspectives whilst being socially responsible (epitomised by the saying "think global, act local"), and increased competition within the job market due to the (ongoing) global financial crises. It is a desperately challenging period, but also a time of real opportunity for improving the content of and strategies for teaching and learning for capacity building the health promotion workforce.

Two key European developments occurred in the past two–plus decades which link health promotion (and public health), with training and education. The Treaty of the European Union (European Union, 1992) gave the European Union competency in the field of public health, and was subsequently strengthened by the Treaty of Amsterdam (European Union, 1997). Alongside these developments, the Bologna Declaration (EHEA, 1999) endorsed the development of a European system of higher education as a single coherent system by 2010. Following these developments, the European Parliament and Council agreed a programme of community action on health promotion, information, education and training within the framework for action in the field of public health. Within this, an integrated approach to health promotion was specifically requested, based on international best practice and considering multi-disciplinary and inter-sectoral approaches to be used in developing health policies of member states. The policy directive resulted in a dedicated programme of funding, which subsequently enabled great progress to be made in developing and delivering training and education for health promotion, for example within the EUMAHP and PHETICE projects (Phase 1 and 2), learning which was then built upon at international level within the Canada Europe Initiative in Health Promotion Advanced Learning (CEIPHAL) and Transatlantic Exchange Partnership (TEP) projects, the latter two of which shifted the focus

from a European perspective to using increasingly global approaches[1]. Within these and many other European and International projects dedicated teams of European and International project consortia came together, shared good practice, developed frameworks and content for training and education programmes, as well as making advancements in the use of pedagogical strategies for health promotion training and education. The latter is both relevant and important within health promotion because this discipline is built upon a strong framework of concepts, principles and values, which should arguably define and underpin both the curriculum as well as pedagogical strategies for course development and delivery. These ideas will be taken forward into the following discussion on strategies for teaching and learning.

## Strategies for teaching and learning

With strong philosophical underpinnings and core set of principles and values, a paper about the need to build capacity within the health promotion workforce requires a discussion on strategies for teaching and learning. This is significant in recognising and ensuring approaches are aligned within the health promotion paradigm and which will produce a HP workforce, equipped with knowledge, skills as well as attitudes, beliefs and values to carry out their roles as effective health promoters.

This discussion has strong implications for developing content, structure, the delivery strategies and methods, as well as for monitoring and evaluation of training and education programmes, both for the teacher as well as for the learners, and at all levels of study, postgraduate, undergraduate, or in-work training programmes. The proposed approach reflects a paradigm shift from using traditional didactic approaches to teaching and learning, to those which empower the learner to take control of their own learning outcomes whilst simultaneously achieving the required learning outcomes of the programme. In short, this approach is driven by the student's actual learning needs and is thus more appropriate as well as actionable.

These approaches have been termed self-directed, student-centred, or experiential learning. In addition, self directed social learning adds another dimension and considers "the cognitions by which people attend to, reflect upon, cues from their social environment in order to strengthen the confidence in their abilities at work (i.e. self efficacy)" (Tams, 2006, p197). Each approach has its own nuances and proponents, further explored within related literature (Knowles, 1975; Burnard, 1999; Taylor, 2000, O'Sullivan, 2003). However, there are more similarities than differences between the approaches used, and common core components enable them to be categorised together for the purposes of this paper. These learning approaches advocate for the need for the individual to be at the centre of his or her learning process, to define his or her learning pathway and to become empowered within the learning

[1] These projects are given as examples of European and International projects which contributed to the development and progress of health promotion training and education programmes and related pedagogical practices. There were many others which equally made major contributions. Unfortunately, the limited scope of this paper does not allow for them all to be acknowledged.

process. The content and context of learning are seen as most important and the teachers' role is seen as supportive and facilitative. Problem-based learning (PBL) is an example of a student centred learning approach which has been documented as being in accordance with core health promotion competencies (Loureiro et al, 2009). This model has been used since 1991 to deliver a series of successful International Summer Schools for HP (see http://www.etc-summerschool.eu/). In addition, the salutogenic approach (Antonovsky, 1996) and Ottawa Charter principles, have been used to underpin a model for learning which has been used in drawing up guidelines for building workforce capacity within a 'training the trainers' programme (Hall and Lindstrom, 2004), which adopted a strong humanistic approach (Colomer et al, 2002). Action learning is another congruent and appropriate experience for those learning through experience, for example, within the workplace. This approach is now widely used within some industries and organisations as an effective way of engaging the learner in reflective learning (Gray, 2001).

How can this body of theory be used to help us as trainers, educators and researchers in facilitating acquisition of competence in a way which remains true to health promotion philosophy?

Knowledge and skills are relatively straightforward to assess, through quantified means or through demonstration by learners, potentially against agreed learning outcomes. The learning outcomes can be formulated against the agreed (HP) competencies which could be based upon those proposed within the CompHP project and/or the NZ Review of HP competencies, and adapted to context and culture. However, attitudes, beliefs and values are more challenging to assess and cannot be easily quantified. Use of relevant teaching and learning methodologies can help to facilitate clearer understanding and demonstration of attitudes, beliefs and values, drawing parallels between concepts and principles inherent within teaching strategies and learning opportunities and those of health promotion. The principles of self-directed learning enable the students to advocate for their individual learning needs, to mediate between their own learning needs and the confines of the context in which they learn, and to feel empowered within their own learning process. These key elements are defined core HP competencies, which can be aligned with attitudes, beliefs and values. Students could therefore potentially be assessed on these aspects of their learning through critical self-reflection, which lends opportunities to demonstrate the ethical values inherent within HP, and linked cogently to their experiential learning journey.

Those of us whose role includes building capacity within the HP workforce all have a responsibility to ensuring we use relevant and appropriate teaching and learning methods. This should include empowering ways of imparting knowledge with opportunities for the learner to experience theory in practice, including opportunity to test, adapt, refine and build a belief, attitude and value set, the outcome of which is a fully competent HP professional.

Another key area for consideration is that of the influence of culture upon learning styles. Research has shown that there is a relationship between learning style preferences and cultural background within higher education programmes (Charlesworth, 2008). In addition, the role of individual differences in terms of self-directed social learning and self-efficacy has

been examined (Tams, 2006), wherein findings indicated women are more likely to engage in social learning, and that antecedents to learning includes agreeableness and extraversion. This research has implications for employability and career advancement. Future research should examine whether socio-economic variables add to the complexity of individual preferences for learning.

## Conclusions

Whilst global health crises become ever more apparent, HP as a profession and an evolving discipline plays an increasingly crucial role in recognising the complexity of health and its determinants, contextualised within political, social and economic parameters and often determined within the settings in which people live and work. The role and remit of health promoters remains extensive and includes promoting, supporting and encouraging inter-sectoral collaboration; advocating and lobbying for changes which will increase our capacity as well as the communities in which we work, towards a healthier world.

As a discipline in its own right HP has in the past been marginalised within Public Health, however infrastructures are gradually being developed to support and develop HP as a recognised discipline, with values relevant to a global audience, but which can also be applied locally, nationally and internationally. Advances made within the field of measuring and assessing HP competence, supported, promoted and endorsed by leading global health promotion organisations such as the IUHPE are testament to the dedication and commitment of key stakeholders, who are working internationally and inter-sectorally, to increase strength, capacity and competence amongst the HP workforce.

The development of HP-specific competencies is vital in defining our plethora of roles within everyday practice, and including the knowledge required to practice effectively and to ensure our work reflects principles and values which truly reflects HP philosophy. This serves to ensure quality and enhances recognition of the HP workforce and the international work currently underway and brings optimism to an agenda that has in the past been developed in a disparate way. We should not be constrained by competencies defined within the HP community but should look to other disciplines in recognition of the need to advance its alliance base and the inter-disciplinarity of our functions as health promoters. Consideration should also be given to the importance of developing cultural competence, particularly in the context that increasingly health promoters exist in a globalising world, involving work across cultures and settings and in view of a lack of existing measures which may help to inform and evaluate cultural competence training (Kumas-Tan et al, 2007).

In recognition of individual learning differences as well as the diversity and complexity of training and education structures globally, a key characteristic of HP training and education programmes should be their flexibility in terms of delivery content, teaching and learning methodologies and their adaptability to the context in which the programme is being delivered. Core components should relate to the learning outcomes for the students i.e. the core HP competencies, with individual needs addressed as relevant (for example, with an emphasis on cultural competence). This will help to ensure coordinated approaches, which

are also able to be responsive to individual learning needs and requirements which may vary across cultures and settings.

This paper has argued that in building capacity of the HP workforce, models of good practice in education and training should be explored and utilised which truly reflect values and principles inherent within HP. Self directed and work based learning are proposed as models which could be relevant and should be explored in more detail by trainers and educators across the globe.

## Moving Forward

It would be naive to make any proposition that centres heavily on reliance of financial resources to progress the issues outlined within this paper, at local, national or international levels. We are living and working with the short and longer term impacts of a global recession, including continued austerity measures and ongoing cuts to health and social funds. However, with the UN Political Declaration on Non-Communicable Diseases in place as well as global momentum to utilise the Health in All policies approach (IUHPE, 2014), now is a crucial time for the HP community to unite, to share resources and to build upon advances made within our evolving discipline over the last 40 years. Fundamental to this process is accessing and harnessing opportunities to utilise inter-sectoral approaches and to build upon evidenced-based practices as a way of increasing capacity within the HP workforce. This should be combined with continued efforts to ensure the quality of these processes and practices, including increasing and recognising professional competence through recognised training and education pathways and which include ongoing workplace assessment. These combined approaches hold the potential to contribute to supporting the processes in which health develops and health outcomes are improved, across the settings in which we live, work and play (WHO, 1986). This can only be achieved if our work is truly collaborative, inter-sectoral, participatory and empowering to the communities we are reaching out to and working within.

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## Biographical note

Caroline Hall is a Research Fellow at the Centre for Health Research, University of Brighton, UK. She has worked in the field of health promotion research, teaching and practice for 20 years. She currently works as a Research Fellow in global health promotion on a wide range of health promotion research projects at local, national, and international levels, in areas including healthy policy and practice, capacity building for health and monitoring and evaluation in health promotion and has presented internationally on related topics. Caroline has played a key role in developing and teaching on the MA International Health Promotion at the University of Brighton and leads a self-directed, international placement-based module. She is an elected member of the European Regional Committee of the International Union for Health Promotion and Education for the last 6 years.