Original Article

Strengthening health promotion practice: capacity development for a transdisciplinary field

Stephan Van den Broucke

Abstract: The growing burden of non-communicable and newly emerging communicable diseases, multi-morbidity, increasing health inequalities, the health effects of climate change and natural disasters and the revolution in communication technology require a shift of focus towards more preventive, people-centred and community-based health services. This has implications for the health workforce, which needs to develop new capacities and skills, many of which are at the core of health promotion. Health promotion is thus being mainstreamed into modern public health. For health promotion, this offers both opportunities and challenges. A stronger focus on the enablers of health enhances the strategic importance of health promotion's whole-of-society approach to health, showcases the achievements of health promotion with regard to core professional competencies, and helps build public health capacity with health promotion accents. On the other hand, mainstreaming health promotion can weaken its organizational capacity and visibility, and bears the risk of it being absorbed into a traditional public health discourse dominated by medical professions. To address these challenges and grasp the opportunities, it is essential for the health promotion workforce to position itself within the diversifying primary care and public health field. Taking the transdisciplinary status of health promotion and existing capacity development systems in primary and secondary prevention and health promotion as reference points, this paper considers the possibilities to integrate and implement health promotion capacities within and across disciplinary boundaries, arguing that the contribution of health promotion to public health development lies in the complementary nature of specialist and mainstreamed health promotion.

Keywords: health promotion workforce, discipline, capacity building

Introduction

Since the Ottawa Charter (1), the practice of health promotion has developed considerably. The health promotion workforce has expanded in size, diversity and competencies; graduate and undergraduate training programmes in health promotion have proliferated across the world; and health promotion organisations and institutions have been established, ensuring a structural basis for a diverse range of activities, programs and projects in a variety of settings, including schools, workplaces, communities, cities and health care organisations.

At the same time, the epidemiological, political and societal context for health promotion have also changed drastically. In the 35 years since the Charter, the world has witnessed a change of the burden of disease, with more chronic conditions and multimorbidity related to rising life expectancy in both developed and developing countries, a growing prevalence of injuries and violence, more stress and mental health problems, and widening health inequalities. Added to this are the health effects of spawning urbanisation, climate change and natural disasters, increasing anti-microbial resistance, and newly emerging communicable diseases like severe

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acute respiratory syndrome (SARS) and coronavirus disease 2019 (COVID-19). These developments take place in a broader societal context marked by financial crisis and austerity, and by an unprecedented revolution in communication technology. The latter provides a potentially powerful tool to increase peoples' access to knowledge and support systems that help to manage their health, but also gives rise to unequal access to health information, which widens the knowledge divide and boosts the influence of potentially health-damaging commercial determinants of health.

All of these changes put existing health systems under pressure. Whereas health services in most developed countries were set up to meet the needs of a demand-led health care with a focus on treatment, cure and care, the changing burden of disease makes these systems less effective and very costly (2). Yet, at a time when governments across the globe are trying to maximise the return on health spending, significant improvements in population health can still be achieved by addressing the factors that produce health, rather than just maintain it (3). Consequently, there is much to say for strengthening the role of public health and for emphasising preventive, people-centred and community-based health services, with a more prominent role for health promotion as part of the wider public health system (4).

In recent years, the idea of integrating prevention and health promotion in health systems and of strengthening the capacity of health systems to be more health promoting seems to be gaining ground. As a case in point, prevention and health promotion are included in the ten 'Essential Public Health Operations' (EPHOs) listed by the World Health Organisation (WHO)'s Regional office for Europe to guide assessments of public health capacities and services (5,6). In 2012, a mapping of the public health capacities in European Union (EU) Member States commissioned by the European Commission included health promotion and actions to address inequalities and the wider determinants of health (7), and, more recently, the European Observatory on Health Systems and Policies is leading a study on the effects of changing competencies and skill mixes across occupational groups within public health (8). These developments have important implications for the health workforce. As new tasks are added to existing professional roles and new profiles and collaborations emerge, the diversifying primary and public health workforce needs to adapt its competencies and skills. Since many of these competencies are at the core of health promotion, health promotion is increasingly being mainstreamed into modern public health, and integrated into competency and accreditation systems for health care and public health.

For health promotion, this development offers both opportunities and challenges. Opportunities, in the sense that a stronger focus on the enablers of health enhances the strategic importance of health promotion's whole-of-society approach to health care and prevention, showcases the achievements of health promotion and helps to build public health capacity through a 'health promotion lens'. But it also represents a challenge, as mainstreaming health promotion may weaken its visibility and bears the risk of it being diluted in a traditional public health discourse dominated by medical professions. This scenario was seen in the UK, where the mainstreaming of health promotion in the beginning of the millennium, although initially welcomed, reportedly resulted in a weakening of its organisational capacity and an absorption of health promotion concepts into an increasingly individualistic public health discourse (9–11).

This contribution considers the place of the health promotion workforce and of capacity building for health promotion within a diversifying primary care and public health field. Starting from a reflection about the place of health promotion in relation to public health, we will provide an overview of existing competency frameworks for primary and secondary prevention and health promotion, and consider possibilities for integration and implementation of these systems within and across disciplinary boundaries.

Health promotion as the new public health

Health promotion's relationship with public health is somewhat ambiguous. While health promotion practice is rooted firmly in public health and often seen as a part of it, it also represents a radical shift from traditional public health approaches, on account of its unique value system. As a reaction to the 'benevolent paternalism' that is believed to characterise traditional public health

thinking (12) in that it relies on the authority of experts and health professionals to determine what the population's health needs are and how they should be addressed (13), health promotion is much more value-driven and concerned with empowerment, equity and participation. Inspired by a salutogenic conceptualisation of health (14), it seeks to bring about positive changes in health. It revives the traditions of social medicine by paying particular attention to those that suffer disproportionately negative health outcomes, and tries to create a dynamic, participatory engagement with individuals and communities to enable them to take control over the determinants of their own health, emphasising that participation is an essential condition to sustain actions on health. These principles are highlighted by the three key health promotion strategies that are specified in the Ottawa Charter, i.e. advocacy to create the essential conditions for health, enabling people to achieve their full health potential and mediating between the different interests in society in the pursuit of health (15). In other words, health promotion takes participation, empowerment and equity seriously, which has profound implications for the way public health interventions are undertaken.

As such, health promotion is more than just a strategy, an 'essential operation', or, as the Bangkok Charter (16) puts it, a 'core function' of public health. Key scholars in the health promotion field argue that it actually represents the avant garde of public health, in the sense that it introduces novel ideas (17): it does more than just pay lip service to the idea that health is a social as well as a biological and psychological phenomenon, and shows the way from a pathogenic to a salutogenic focus on health. In fact, the mission to renew public health was already present in the Ottawa Charter, which after all was subtitled 'the move towards a new public health' (18).

This radical ambition to change public health does not always translate into the practice of health promotion, where tensions continue to exist between those who stay closer to health education and use models of behaviour change that are linked to biomedical positivist methods, and those who want to address the wider (social) determinants of health—the 'causes of the causes'—through structural interventions and measures that go beyond the individual. Yet, despite these differences, there is little doubt that health promotion stands for a profound change of the course of public health, through its emphasis on positive health, social influences on health, participation and empowerment. A 'new' public health that incorporates these values and principles needs to address the collective lifestyles of modern societies as well as the influence of the social and physical environment on the population's health and quality of life, while handing the control over these influences back to the people themselves and strengthening their capacities to deal with them.

The health promotion workforce

Unlike the medical workforce with its clearly established professions and career structures, the workforce for public health and health promotion is more difficult to describe and define. As a result, many different definitions coexist. Rotem et al. (19) distinguish public health workers from medical practitioners and define them as 'people who are involved in protecting, promoting and/or restoring the collective health of whole or specific populations', thus stressing their societal role. Beaglehole and Dal Poz (20) refer to the public health workforce as those 'whose prime responsibility is the provision of core public health activities, irrespective of their organizational base', highlighting that they can operate both inside and outside the health sector. In a similar vein, the Centre for Workforce Intelligence in the UK distinguish between a 'core' and a 'wider' public health workforce by defining the latter as 'all staff engaged in public health activities who identify public health as being the primary part of their role'. The US Institutes of Medicine include an educational component in their definition, and characterize the public health workforce as 'persons educated in public health or a related discipline who are employed to improve health through a population focus'.

These definitions focus on the public health workforce in general, without explicitly mentioning health promotion workers. As an evolving field, health promotion has a very diverse workforce, drawn from a broad range of disciplines. The Ontario Health Promotion Resource System, for instance, defines health promotion workers as 'those who work to promote health as defined in the Ottawa Charter regardless of professional

designation', adding that the definition includes 'people, organisations, and groups from various sectors', and that 'health promotion work may be paid or voluntary' (21). Although an increasing proportion of the health promotion workforce in industrialised countries has qualifications specific to the area, many people working in health promotion come from different educational backgrounds and received little formal training in health promotion (22). However, it is recognised that there is a specific body of skills, knowledge and expertise that represents, and is distinctive to, health promotion.

While the core of the public health or health promotion workforce are those who identify (public) health as their primary professional role, there is a growing awareness of the role for the 'wider' public health workforce, i.e. people who are not involved directly in public health or health promotion activities, who tend not to perceive themselves as being part of the public health workforce, but whose work nevertheless contributes to improving population health. This group includes health professionals such as midwives, community pharmacists or general practitioners (GPs) who may promote public health as a part of their jobs, as well as other professionals who are not working in the health sector but whose work can have a significant impact on population health, such as teachers, urban planners, architects, police or journalists (23,24). Their expertise may complement that of the core group of professionals to achieve a coordinated response to the social determinants of health. The core workforce can also act as a catalyst to support evidence-based interventions that are undertaken locally by competent health practitioners and the wider workforce.

The move towards expanding the public health workforce to include a wider group of professionals emphasises the multidisciplinary and diverse character of public health itself. Acknowledging and explicitly addressing the role of the wider workforce to promote population health is a necessary step towards dealing with the multidisciplinary nature of contemporary public health challenges. Yet a formally recognized core of public health and health promotion professionals remains necessary. An assessment of public health capacity in the EU in 2013 revealed that countries were generally stronger in traditional fields of public health, such as communicable disease control and vaccination, and weaker in addressing the social determinants of health and health inequalities (7). Thus, enhancing the capacity of the public health system to address emerging public health challenges cannot be achieved only by increasing the numbers of people who work in health, it also requires an investment in building the skills and competencies of that workforce.

Core competencies for health promotion

As a key dimension of the broader public health capacity (25), a well-trained health workforce has always been considered an essential condition for the delivery of effective health services. The diversification of the public health workforce and the growing recognition of prevention and health promotion therein provide opportunities to add new skills and tasks to existing professional roles end to enhance collaborations between professions. This has created a momentum to introduce the idea of core competences in health promotion and public health. Competences (or competencies—the terms are used synonymously) have been developed in the context of capacity building and workforce development as a means to develop a shared vision of what constitutes the specific knowledge and skills that are required for a given function. They can be defined as a combination of attributes (knowledge, abilities, skills and attitudes) that enable an individual to perform a set of tasks to an appropriate standard (26). In education, they can serve as an important reference to clarify expectations, define future professional needs for graduates, and provide a focus for the development of curriculum and course design.

Over the past decades, a number of reviews have been conducted of the competencies that are required for health promotion and for the related discipline of public health, in different regions across the world (26–28). As a result of these efforts, a consensus has been reached on an elaborate and detailed set of core competencies that health promotion specialists need to possess. These are set out in the Galway Consensus Statement (29,30), which served as a basis for the development of a comprehensive set of 68 professional standards for health promoters through the EU-funded CompHP project. The standards subscribe to the ethical values and principles of health promotion (belief in equity

and social justice, respect for the autonomy and choice of individuals and groups, and collaborative and consultative ways of working) and to a multidisciplinary health promotion knowledge base as guiding practice, specified and developed within the other core domains/clusters (enable change, advocate, mediate, communicate, lead, assess, plan, implement, evaluate and research). The International Union for Health Promotion and Education (IUHPE), as the main driving force for professionalisation of health promotion globally, has been instrumental in taking this work forward by developing an accreditation mechanism for health promotion specialists and university courses worldwide (31).

This accreditation system serves as a valuable inspiration for other public health areas, where core competencies, standards and accreditation mechanisms are also being developed (32–34). For instance, in the UK the Public Health Register requires public health practitioners wishing to apply for registration to go undergo a rigorous process of assessment to demonstrate their knowledge, understanding and application of 34 standards related to 70 core competencies categorized within 13 functions. The 'public health function' referred to in these standards is defined in the Public Health Skills and Knowledge Framework 2016 as 'improving and protecting the public's health and reducing health inequalities between individuals, groups and communities, through co-ordinated system-wide action (35)'. As such, the core competencies that have been, or are being, developed for public health also refer explicitly to health promotion. Likewise, in Canada a group of health promoters within Health Promotion Canada (HPC) developed a set of specific health promoter competencies, building upon the core competencies for public health developed by the Public Health Agency of Canada (PHAC), but providing greater detail regarding the knowledge, skills, and abilities necessary for the practice of health promotion. The competencies come with a series of tools to support the use of the health promoter competencies by students, practitioners, managers and academic instructors.

While an increasing number of countries have specified competencies for public health and health promotion practice, the implementation and use of these competency frameworks varies greatly. Some countries specify a minimum level of competency expected of all public health workers, while others have different expectations for varying seniority (36).

An element of debate is also whether standards and accreditation mechanisms are a necessity to achieve proficiency in the core health promotion competencies. Whereas the Galway Consensus Statement recommends that each country or region would develop or adopt quality assurance mechanisms in accordance with the prevailing political, economic or cultural context, health promotion professionals and organisations in some countries have taken a cautious stance on this issue, fearing that the process that is required for health promotion to become a formally accredited and regulated profession could be rigorous, time-consuming and potentially divisive (35). An alternative approach could then be not to promote the competencies as a step towards the mandatory accreditation of health promoters, but as a way to inform and stimulate dialogue towards agreement on a requisite skill set for health promotion training and practice.

Despite these different viewpoints on the way to roll out the core competencies, it is clear that the use of a consensual, comprehensive set of professional standards for health promotion professionals is generally welcomed. The core competencies can play a key role in the underpinning of future health promotion training and course development, continuing professional development, and accountability to the public for the standards of health promotion practice. In a broader sense, they can also contribute to the consolidation of health promotion as a specialised field of practice.

Health promotion as a discipline and profession

The move towards an integration and mainstreaming of health promotion principles and strategies into public health offers unique opportunities to bring in a health promotion perspective and reorient public health interventions more towards addressing the social determinants and other enablers of health, to emphasise the strategic importance of a positive and whole-of-society approach to health care and prevention, and to strengthen the importance of participation

and empowerment of individuals and communities. It also gives a chance to bring a health promotion perspective to public health capacity building (37) by introducing specific health promotion competencies into public health professional standards and accreditation systems. But mainstreaming health promotion can also challenge its uniqueness. Experiences in the UK, Canada and Australia have shown that mainstreaming the ideas and strategies of health promotion in the early 2000s led to their absorption into a traditional, individualized public health discourse, dominated by other, usually medical, professions (11), and even to the disappearance of the term 'health promotion' itself: in England, it was replaced by 'health development' and, later on, by 'health improvement'; in Canada the term 'population health' was introduced as an alternative, and in Australia the term 'preventative health'. Although this change of names and terminology for reasons of political convenience obviously did not imply the loss of health promotion expertise (specialists trained in health promotors continued to work in the public health systems and even held leadership positions), it did result in a loss of visibility and identity. The same has been noticed in international agencies like WHO and the Pan American Health Organisation (PAHO), where mainstreaming health promotion as a cross-cutting topic across the organisation resulted in a loss of dedicated champions, visibility and power (38). This may have as a consequence that the importance attributed to health promotion within governmental and academic institutions also decreases, resulting in a reduction of capacities to train new scholars, carry out research and interventions, and foster collaboration and exposure to innovative ideas (39). Interestingly, in Canada the term health promotion has recently been re-introduced, through the establishment of HPC in 2016. In the UK, on the other hand, the plan to name the newly established governmental department that hosts the former Public Health England health improvement staff as 'Office for Health Promotion' was not retained, and the department is named 'Office for Health Improvement and Disparities' instead.

As argued by Van den Broucke (37), this risk of identity loss can be attributed partly to the unclear disciplinary status of health promotion and the fuzzy professional identity of health promotion workers. A field of study is considered a discipline when it has its own specific knowledge domain, history, value base, traditions, codes of conduct and preferred research methods; to be considered a profession, it needs a recognised workforce, overseen by a body that implements professional competency and accreditation methods (38). Health promotion certainly has many of the attributes of a discipline: it has its own set of concepts and values, crystallised around holistic and emancipatory approaches that promote health equity, social justice, participation and empowerment; it is well grounded in relevant theory (40,41); it applies a methodology that involves a shared understanding of what constitutes good practice; and it supports a notion of 'evidence' that is wider than that of public health and medicine in order to capture the complex interactions between various determinants of health, situated at different levels (42). But health promotion is not based on a single paradigm with its own epistemological, theoretical and methodological foundations; it borrows its theoretical and disciplinary roots from longer established disciplines, such as sociology, psychology, education science, political science, communication science, marketing and ethics (41,43). As such, health promotion is essentially transdisciplinary.

Health promotion also meets some, but not all the criteria to be considered a profession. There is indeed a large offer of university training programmes and courses, handbooks, journals and conferences dedicated to building the competencies of the health promotion workforce, as well as core competency systems with professional standards and accreditation systems for health promotion specialists or training courses that are gradually being implemented. There is also a global network of governmental and nongovernmental organizations that support the development and implementation of health promotion programs. Yet in most countries there is no distinctive institutional structure or professional body that oversees health promotion practitioners and guarantees that their qualifications meet the agreed-upon standards, which means that, in practice, anyone can call him/herself a health promotion professional (43).

Mainstreamed versus specialist health promotion

The transdisciplinary nature of health promotion and its status as an emerging (as opposed to an established) profession make the goal to make public health more health promoting challenging. While there is an opportunity to integrate the concepts, values, strategies and methods of health promotion into the practice and teaching of public health, this should be done without sacrificing its identity and status.

To achieve this double-edged goal, it may be important to differentiate more clearly between specialist and mainstreamed health promotion. The first refers to a scholarly body of knowledge and practice, with its own specialists contributing to the field at academic and professional levels, while the second designates health promotion as a social movement, embedded in the work of people who work to promote health as defined by the Ottawa Charter, regardless of their professional designation. Health promotion specialists, both academics and professionals, may work in organisations dealing with various aspects of health, while mainstreamed health promotion can also take place outside the health sector, for example, in schools, sport and fitness settings, workplaces, prisons, etc. According to Davis (38), the training backgrounds of health promotion specialists are manyfold, and vary in different parts of the world. In North America, for instance, health promotion specialists often have a training in nursing, social work or education, whereas in European countries like France and the Netherlands they are often trained as health educators. In Africa and South East Asia, on the other hand, health promotion programmes are led mostly by professionals trained in public health and implemented by health education and communication specialists. Academic health promotion is dominated mostly by the disciplines of public health, health education and health psychology, whereas health promotion in practice is shaped by public health and education professions (44). These differences reflect the complexity of the health promotion specialist profile and, as such, underscore the need for comprehensive, agreed-upon professional standards for health promotion professionals.

The complementary nature of specialist and mainstreamed health promotion can be the key to the contribution of health promotion to the development of public health. Mainstreaming health promotion can ensure that the holistic and empowering approach of health promotion, with its emphasis on equity, social justice and participation, finds its way in the broader public health domain, and that it is reflected in the training curricula and professional standards of public health specialists. On the other hand, training and supporting a core body of health promotion specialists within academia, policy and practice settings can help to maintain the identity and traditions of the field, and further advance the body of knowledge, values, competencies and research methods that make health promotion unique.

Conclusion: capacity development for a transdisciplinary field

The contribution that health promotion can make to health care and public health answers a true academic and societal need. In the wake of the epidemiological, political and societal changes the world has seen over the past decades, health systems need to adjust their problem-oriented, technical and top-down approach to addressing health problems, and focus more on health as it is experienced by the people themselves. To do so, public health and health care workers need to become more competent at acknowledging and attending to the needs of individuals, organisations, communities and networks, and at enabling them to promote health in a self-determined and sustainable manner.

Health promotion is the only 'specialism' within the health system that has these competencies, and that has the professional and organisational capacity to continually develop, update and disseminate them. In this way, health promotion specialists need to advance the knowledge, values, competencies and research methods of health promotion and train, support and build the capacities of not only other health promoters, but also of a widening group of other health workers. The continuing development of health promotion as a transdisciplinary field of practice can thus nurture the broader group of mainstreaming health promoters, without losing its unique identity.

To direct and guide this process of competency development, comprehensive systems of agreed-upon core professional competencies and

professional standards for health promotion are extremely valuable. The core competencies, professional standards and accreditation systems developed through the CompHP project, the UK Public Health Skills and Knowledge Framework, and HPC, which all subscribe to the values and principles of health promotion, not only represent a major driving force for the further professionalisation of health promotion workers, but are also instrumental to integrating the concepts, values, strategies and methods of health promotion into the practice and teaching of public health.

The development and implementation of core competencies for health promotion as a means to enhance the professionalisation of health promotion and to strengthen its role within public health should be considered as a part of a broader capacity building process. As pointed out by Aluttis et al. (25), public health and health promotion competencies are to be distinguished from capacities: the first are concerned with identifying, describing, assessing and ascertaining the knowledge, competencies and values that are required of public health and health promotion professionals as a basis to guide professional training; the latter refer to a broader concept that looks at the characteristics of the system for public health as a whole. Workforce development, of which core competencies are an important element, is but one of a series of dimensions that make up the capacity of a public health system, next to knowledge development, resources, organisational structures, partnerships, leadership and governance, and the country-specific context (25). Existing frameworks for public health and health promotion capacities highlight the importance of all these dimensions to build effective public health systems, and note that they are often interdependent. This means that the development of the public workforce is only one—albeit important—way to make the shift towards a more prominent role for health promotion in public health. It also means that the chances of successfully strengthening the health promotion workforce depend on other factors, such as a leadership and governance that is supportive of health promotion, allocation of sufficient financial resources, adequate institutional and organisational capacity, research in health promotion, and formal and informal partnerships. Only if these capacities can be strengthened, will health promotion flourish as a transdisciplinary field of practice and as an emerging profession that can help build more preventive, people-centred and community-based health systems.

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