

Education and training in health promotion: theory and methods

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SUMMARY

Health promotion is evolving into a discrete concept with a definition commonly understood by all who use the term. This is to be distinguished from the kind of umbrella approach used by all manner of groups and disciplines to define their intentions or activities in this general area. Further, such a process of clarification is critical to progress and is dependent on having a theoretical basis through which research can be undertaken. In turn, the education of those engaged in health promotion can be expected to shape their skill range and perspective. We find, therefore, a kind of interdependent and reciprocal situation is developing.

At the present time, for chronological reasons as much as anything else, practitioners of health promotion come from a variety of academic and training backgrounds. The process of enabling individuals to take control of their own health involves a wide spectrum of determining factors and hence expertise is very varied. Two key elements, for this writer at least, are

these: the approach is positive and holistic rather than reductionist, and context is recognised as a major factor in health choices.

This paper seeks to discuss the priorities for education against this background. It uses as resource the proceedings of a workshop on education and training held as part of a World Health Organization supported workshop held in Copenhagen in 1992. We find that most graduate level training is in dedicated Master level programmes that have considerable overlap with those in public health. Discussion will centre on whether we have sufficiently evolved our thinking to discriminate skill areas unique to health promotion that should be taught. The intuitive basis on which courses have developed to date will be examined. Finally, the paper asks whether or not the standardisation that may follow is in any way antithetical to the embracing principle of health promotion itself.

Key words: education; health promotion; training

This paper examines the implications of theory development for education and training in the field of health promotion. I hope to reflect on how the theoretical developments seem to me to set an agenda for educational initiatives. In its course, I will describe some of the thinking behind the establishment of my own chair in Ireland and how we have evolved our projected teaching programme. I will discuss some of the other models in this field, particularly in the neighbouring United Kingdom, with which I have had some contact.

What we now understand as the field of health promotion has grown rapidly in the past decade. The Ottawa Charter, arising from the eponymous

conference in 1986, undoubtedly provided a timely focus for this development by bringing together interested practitioners from around the world and by producing a set of principles that could be said to constitute components of health promotion. In historical terms, the two relevant paths leading to this conference were the evolution of health education since the Second World War and at the same time the decline and subsequent rejuvenation of the public health movement (Ashton and Seymour, 1988). The Ottawa Charter sets out five core areas for health promotion: healthy public policy, personal skills development, the creation of supportive environments, community

participation and the re-orientation of health services. It also recognised as mechanisms for health promotion, enablement, advocacy and mediation. What the document represents is a synthesis of approaches and ideas from a spectrum of disciplines and it sets, for the first time, parameters within which a body of theory and practice might be established. At the same time, the ambition and scope of the Charter has to be acknowledged, and for practical purposes the creation of health promotion practitioners and theorists who might take the subject forward, means a stringent review of educational methods. It is with the latter area that this paper is concerned.

The literature base that informs our work might have moved away from the concept of victim blaming, whether in health education or in health promotion, but there is widespread evidence that the general public and media reporters have not evolved at the same pace. Thus, health promotion is rapidly understood by the general public to mean a preoccupation with lifestyle behaviour, particularly in relation to smoking, alcohol consumption and diet. Accordingly, endeavours to understand what promotes, maintains or demotes health become defined by measures of its absence in specific contexts and disease processes. More importantly, public demand in democracies dictates that public policy and research funding follows the guidelines set by the prevailing paradigm of what constitutes health. That external pressure in itself should be a stimulus to practitioners and to teachers of would-be practitioners to examine definitions. There is now a growing consensus among those interested in the field about what might be included legitimately in the investigative sphere of health promotion. What needs to be asked, however, is what methodological approaches might be employed and thus what kind of theoretical basis this might have. This issue has not been neglected in recent times. The contribution of qualitative research to health education and particularly its relationship to quantitative methodology, is of considerable practical interest (Nisbet and McQueen, 1992; Tilford and Delaney, 1992).

Perhaps the best reminder (for those who are in doubt), of what a potential Tower of Babel health promotion can be, is the difficulty for a health promoter in explaining his or her occupation at a social occasion. There, stripped of the protection of work colleagues who have a good day-to-day idea of what one does, one has to search for meaningful ways of conveying what it involves

and often consciously disabuse the listener of preconceived ideas. There is a natural tendency in such instances to revert to one's parent discipline, by which one usually means the original nature of one's undergraduate training and subsequent specialisation. Health promotion at academic and service level is a specialism employing a variety of medical, paramedical, biological and social scientists (listed here, let it be said, in no particular order of importance). To the extent that people understand the term 'public health', this can be a helpful solution to one's dilemma with job description. This most fundamental of problems relates, of course, to the definition imposed by a theoretical base. A succinct definition is required so that people unfamiliar with the health sector can distinguish one kind of professional from another. Accordingly, one has to seek ways of defining what one has in common with other professional health promoters, a line of thinking that leads naturally to a discussion of what the training needs might be. At this stage, we encounter something of a paradox because health promotion owes much presently to visionary, eclectic thinking on the part of people who, at a particular career point, found themselves engaged in different activities, possessors, as it were, of one piece of the puzzle and curious enough to look for the other pieces. To define now what the training needs are, at undergraduate or postgraduate levels is to seek to limit entry to the field and by so doing, potentially at least, to narrow skill-bases. Can an environmentalist, a food economist, an adult education teacher, a physical fitness coach, for example, all call themselves part of the same club? The definition will certainly dictate the type of student group one is likely to attract. Clearly, all the practitioners above will require different skill-bases but each may share some common training on the context and perspective that is health promotion. It is the nature and extent of that training that needs definition.

At present, education in health promotion is seen as applied so there are two main target situations. Firstly, practical training programmes that are particularly used in the field of health education and involve a whole spectrum of skills development in fields like assertiveness training and stress management. The learning style is participative and experiential and the objective is to train persons in the practice of such health education and promotion initiatives as are policy in their work situation. Increasingly, such pro-

grammes have tended to incorporate health promotion into their titles and this has been reflected in their subject matter. However, they remain focused on individual empowerment as a means of effecting social change. Such programmes may also adopt a more traditionally academic approach, largely through third-level institutions, and geared particularly at graduates or equivalent professionals. There is more emphasis on knowledge acquisition and experimental method in this latter kind of programme, which is more likely to produce research-oriented persons with little premium on practical experience. The second source of education is through the Master's degree in public health. Again, the curriculum will vary appreciably from country to country and even within countries. Such programmes tend to the academic teaching approach, may be aimed exclusively at medical graduates or include other health professionals, will place strong emphasis on disease surveillance and epidemiology and hence on public policy and social change as means of promoting health.

Both are clearly legitimate courses of education, but they have different objectives. Arguably a synthesis of the two processes of learning might also be appropriate. Health promotion is fundamentally about empowerment. It explores barriers to empowerment at individual, community and national level. Barriers may arise variously from lack of explicit personal control or understanding, from a failure to appreciate one's options in a situation of conflict or because of a failure by some in power to acknowledge and provide appropriately for the public health. Necessarily, therefore, ways of recognising and overcoming these barriers have to be evolved and methodologies of interpretation and evaluation which are both qualitative and quantitative will need to be taught. A student trained exclusively in one methodological direction will not be sufficiently skilled to meet the challenge of a complex health promotion problem. At the same time, a student trained in every direction will not have time to be anything but a perennial student. Accordingly, a core curriculum needs to be evolved for third-level courses in health education and public health, with speciality pathways and with particular provision for practice or research. It should be a principle of any good educational system that the person is equipped to solve the problem rather than the converse where the person interprets the problem according to his or her capacity to solve it. The following

parable, a parody of the folk song, illustrates the point.

A twist on Liza and Henry and the hole in the bucket:

Liz asks Henry to take the bucket to the well and fill it with water. . . . But there is a hole in the bucket, a small hole. He returns with a bucket full or large stones. Henry says, 'I've filled the bucket, dear Liza'.

She says, 'but with stones, dear Henry, with stones!'

Henry says, 'But there's a hole in the bucket, dear Liza, a hole. I could not fill it with water, so I had to fill it with something that wouldn't fall out.'

The Moral: Do we use the inappropriate instruments just because we can, on occasions?

A further feature of the emerging discipline of health promotion is the absence of those who might be, for the want of a better word, morally motivated. That very absence is in itself a mark of development, though this value-neutral approach to scientific thought has itself ceased to be unquestioned. This leads us to ask what motivates persons to become interested in the field of health promotion and will that motivation in any way influence the direction of their practice or research activities? The fascination with health promotion is a complex one to unravel; it may be with determining the nature of health, with exploration of health as a resource for everyday living and with the elucidation of the impediments to its maintenance, be they personal, social, cultural or physical. There is no doubt that the notion of developing control over one's health should be seen as a continuum with complex and multifactorial determinants. The skills for the practice of health promotion will certainly involve good communication abilities, qualities of empathy and mediation, a sense of proportion and context, practical management skills and whatever specific requirements are defined in the job undertaken. On the other hand, the researcher needs a variety of other abilities, some common to any researcher in the field of science everywhere, some more specifically related to health promotion. The core task for the researcher will be the examination of how the individual fares in any social predicament and whether the interaction influences his or her health status for better or worse. What assessment tools are required? We need to have outcome measures, therefore positive definitions of health and ways of measuring

them. We need to factor in qualitative elements like motivation, processes of imparting views between persons and any distortion arising from interaction between researcher and study participant. For quantitative analysis, we have to take account of interaction between risk factors, of relative time influences on variables and between different people. For example, take Mr Jones and Mr Smith, near neighbours of the same build, working in the same factory with identical size family units and common lifestyles. Mr Jones dies of a heart attack on his fiftieth birthday, but Mr Smith survives until retirement age. Neither has a significant family history of the disease. Professor Geoffrey Rose (1990) used to ask, 'why this person, of this disease, at this time?', and it is a good question. To say that we do not know everything is not to say that we know nothing. For instance, the example above does not refute known epidemiology, it may suggest as yet unexplained risk factors, but it also suggests a need to examine the interaction between risk factors and the role of time. It may also be a matter of perspective. Should we be researching why Mr Jones died or why Mr Smith survived? The health promotion researcher therefore needs to understand quantitative and qualitative methodologies and to retain considerable curiosity along with these skills.

As in so many fields of human learning, we are a product of our past rather than *ab initio* innovators of completely new approaches. Health education necessarily depends on individual interaction and so was heavily influenced by psychology and education, as well as its biomedical associations. Health promotion, however, is concerned with patterns and so sociology, anthropology and now a whole variety of environmental sciences are involved, as well as more traditional epidemiology (Ashton and Seymour, 1988). There is a need for vigorous examination of the research paradigms on which such social research is based, including a closer inspection of the precedents in the physical sciences (Dean, 1993). The recognition of complex interaction in real-life situations and the necessity of detecting and predicting this accurately has to be explored. The question here is how this might influence education in health promotion. If it is true that empirical researchers can successfully operate in the field of health promotion without necessarily developing an operative theory base, then it might not be so problematic. However, there is undoubtedly a risk of complacency in this approach,

which is compounded by the uncertainty as yet about the discrete nature of health promotion.

In the meantime, there are many more apparently immediate and practical problems in establishing educational programmes in the field of health promotion. In Ireland, my own country, the chair of Health Promotion was established as an independent research and teaching department in an Irish University to complement a revised national health promotion structure. This included (i) an executive and policy unit in the Department of Health, (ii) an inter-sectoral National Advisory Council on Health Promotion and (iii) a cabinet sub-committee comprised of ministers from relevant Government departments and chaired by the Minister for Health.

One objective of the chair, on which I intend to concentrate for the purposes of this paper, was to provide the kind of education and training (at third level at least) required by professionals across all disciplines who might be engaged in health promotion (Kelleher, 1992). The demand was undoubtedly there in the health sector itself and in the teaching professions. A survey of graduates of a diploma programme in health education run in University College Galway through the 1980s revealed a typical client group.

Table 1: Diploma/Master's Programme in Health Promotion UCG: available modules

Core
Concepts and principles of health promotion
Healthy public policy
Education theory and practice
Psychology
Community development
Causes of mental ill-health
Causes of physical ill-health
Biostatistics
Epidemiology
Research methodology in social sciences
Optional
Human structure and function
Health promotion at work
Health promotion at school
Health promotion in primary care
Communication and media skills
Environmental health
Drugs and society
Diet, nutrition and health
Computing
Promotion and protection of breastfeeding

One-third were nurses, one-quarter teachers, and the overwhelming majority women (Dineen and Kelleher, 1995). There is also a significant interest in health issues generally among the wider community too. Uptake of community health education programmes sponsored by the local health board revealed again that the majority were women, likely to be married, aged between 35 and 50 and to have children. It can also be seen that most of those attending courses were likely, in the main, to be involved in personal skills development and hence to be health educators (McNamara, 1991). This experience is likely to be similar across countries in various degrees of sophistication as health education programmes have developed. The other key area of overlap is in the field of public health, both for the medical profession and increasingly in multidisciplinary programmes, where the recruitment means more biomedical scientists are involved.

With this in mind, our department began first by offering modules as part of existing graduate programmes or by undertaking supervision across departments. Thus we developed, for instance, a module on the 'Health Promoting School' concept for the higher diploma in education, which trains teachers at second level and a module on 'Health Promoting Public Policy' for the political science and sociology programme. Those undertaking minor dissertations for Master's degrees in diverse fields such as Community Development, Rural Development, Business Studies and Occupational Health all undertook research topics relevant to health promotion. The modular programme we have now developed resembles in key respects Masters' programmes in public health. The diploma programme is recognised by both Arts and Medicine Faculties and is open to anyone with an appropriate professional qualification and, on an *ad hominem* basis, to those who can demonstrate a particular interest in the field whatever their background. Twenty modules are offered annually, of which 16 must be completed to gain the diploma. Ten of these are regarded as core and six of the remaining ten options must be selected (Table 1). The Master's component of this programme is a satisfied by conducting a piece of original research in a topic relevant to health promotion, presented as a research dissertation. Our graduates to date have tended to come from health and education sector backgrounds and mainly plan practical careers.

There is no doubt that some of those undertaking programmes of this kind have a practical

need for a qualification to equip them in the delivery of health education and promotion programmes. What is also of concern is to create the option of developing research skills for advanced or in-depth work in this field. A PhD programme, perhaps contributed to by a variety of research institutions with different interests around the European region, might well be more appropriate for this.

A survey of members in the Health Promotion Counterparts group and WHO Collaborating Centres in Health Promotion associated with the European Regional Office (Dean, 1991) found a broad range of programmes on offer through a variety of institutions including health institutes, university public health departments, schools of public health, social science or medical speciality departments of universities and health education units. The Master's level programmes were either health promotion qualifications or part of public health programmes. The curriculum content was largely similar to my own programme described above. That survey tended to support the thrust for a health rather than a sickness model as a basis for the teaching programme. The integration of knowledge and methods from the social sciences was marked. The anxiety about the level of scientific standards was also borne out, and many of the issues relating to the methodological shortcomings were emphasised.

In 1993 in the United Kingdom, Jenny Moon (personal communication) undertook a survey of courses on behalf of The United Kingdom Professional Development in Health Promotion project. She found that 29 respondents to her survey across the United Kingdom were offering courses in either health education, health promotion, or both. Of these, ten used health promotion in the title, seven used health education, six used a combination of health education and health promotion, four were incorporated in master's degrees in public health and two were in the field of social studies. All but four offered the qualification to Master's level. Most were modular in form and many appeared to employ a rolling credit format, through certificate and diploma phases.

Both of these surveys confirm the organic development of health promotion education, both a part of the much older health education movement and from the traditional public health field. What must be asked is whether the expansion of curricula to encompass health promotion is creating unwieldy programmes beyond the

competence of students within a calendar year. One solution to this involves a core/option approach which might successfully stream students destined for different career applications and also afford the development of more theoretically based options in future. This necessarily demands resources however.

What practical initiatives have been undertaken to date? It has been recognised for several years that some concerted response in the European region is needed to address public health training. The WHO and ASPHER created a joint task force to develop a European Master's degree in Public Health, based on Health for All principles. Following considerable consultation and exchange of ideas about curricula, it was felt not to be possible to establish such a programme. Instead it was agreed to use peer review and validation approaches between countries and through the establishment of consortia of schools with different strengths. Appropriate supporting infrastructure has also been proposed. The principles on which this is founded, of multi-disciplinary input, of practical field experience and experiential learning and of transnational exchange of ideas, are important and to be welcomed. Training for research, however, will also need attention to the theory and methods of health promotion referred to earlier in the paper.

CONCLUSION

So, where should we be going from here? Firstly, there is a need to establish what exactly we collectively think we are. That sense of professional recognition is one way to establish a boundary for research endeavour. This should not, however, be identified in any sense as confusion. Natural interdisciplinary rivalry must create some basis for an applied area of activity that can be enriched by multiple primary disciplines. To a large extent we are fortunate that wider philosophical debates about the nature of scientific investigation come at a time when it is not only respectable but imperative to examine the relative merits of applying different paradigms to different problems.

The pressing need for practical skills in a variety of applications has tended to overshadow the obvious gap in resolving these theoretical issues. I would maintain that the demand for training has also dictated to a large extent the kind of courses that are available. The very diversity of

that demand has necessitated ever more unwieldy programmes that must now be rationalised. Moreover, there will have to be some recognition of the need for rigorous research skills and a coherent academic career path in this field as well.

Finally, I would say that the Tower of Babel has its merits in one key respect. Listening to ideas you have never been trained to hear before is a remarkably useful way of learning. What all research method has in common is the curiosity for knowledge and health promotion itself as it stands today is a tribute to that kind of inter-sectoral listening. Standardisation of recognised programmes across the European region has its merits for the many reasons expressed in this paper, as long as this retains a broad-based and inclusive spirit.

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