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Fostering a Paradigm Shift in the Roles of Health Promotion Education in Southeast Asia

Marc Van der Putten (Corresponding author)

Faculty of Public Health, Thammasat University

Rangsit Campus, Klong Luang Piyachart Bld. 10th Fl. Pathumthani, 12121, Thailand

Tel: (+66-81-830 3864) E-mail: mvdpt@tu.ac.th

Albert S. Makone

Faculty of Public Health, Thammasat University

Rangsit Campus, Klong Luang Piyachart Bld. 10th Fl. Pathumthani, 12121, Thailand

E-mail: albertmako@gmail.com

Ephraim T. Chiriseri

Faculty of Public Health, Thammasat University

Rangsit Campus, Klong Luang Piyachart Bld. 10th Fl. Pathumthani, 12121, Thailand

E-mail: ephraimtc@gmail.com

Nuntavarn Vichit-Vadakan

Faculty of Public Health, Thammasat University

Rangsit Campus, Klong Luang Piyachart Bld. 10th Fl. Pathumthani, 12121, Thailand

E-mail: nuntavarn@tu.ac.th

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Abstract

In the context of an evolving domain and the complexity globalization adds to the situation, health promotion practice in Southeast Asia face challenges posed by the growing gaps between practice needs, human resource development needs, and educational program development needs. One of the challenges is how to foster a much needed paradigm shift among those responsible for workforce production in health promotion. In this paper, we provide practical proposals for action that provide leverage in thinking differently about health promotion practice. These proposals reflect the authors' perspectives and experiences in competencies relevant to health promotion key action areas: empowerment, health services, partnerships and alliances, environments, and health and policy. We first describe the developments in the health promotion domain; summarize competency frameworks for health promotion; to arrive at a comparison of Southeast Asia education programs for health promotion with programs in socio-economic advanced regions. We suggest proposals on the way forward aimed at fueling the required paradigm shift in capacity building for health promotion in Southeast Asia; and conclude by considering the role national and international alliances can play in implementing these proposals and improving workforce production for health promotion in Southeast Asia.

Keywords: Southeast Asia, health promotion, challenge, education

1. Introduction

The evolving domain of health promotion has been facing challenging obstacles for decades to move beyond behavior change models by complementing professional competencies with a whole new set of

responses to create social conditions favorable for health.

It is assumed that most, if not all, of the education programs in health promotion in Southeast Asia reflect the struggles as pointed out and the consequences this brings to curriculum development.

Although, agents of change in health promotion capacity building seem to situate in socio-economic advanced countries; it remains unclear to what extent their vision has been adopted by education programs in these regions.

The Southeast Asian region offers a kaleidoscope of socio-economic development however various countries in the region experience steady change shaping the societal context which fuels the need for a paradigm shift in promoting health. The World Health Organization-Southeast Asian Regional Office (WHO-SEARO) and the South East Asian Public Health Educational Institutes Network (SEAPHEIN) foster desired change in health promotion workforce production through advocacy, network development, and support mechanisms.

Therefore, it was of interest to review in addition to health promotion programs in Southeast Asia those programs of leading institutes in socio-economic advanced countries within the development spectrum (e.g. Australia, Canada, Europe, USA) to explore the key question: “to what extent do curricula respond to or ignore the paradigm shift in health promotion?”.

By addressing this question our analysis aimed to provide input to the process of change in health promotion capacity building within Southeast Asia. In this paper, we provide practical policy proposals on ways schools of public health can respond to the paradigm shift in health promotion. These proposals reflect the authors’ perspectives and experiences in disciplines relevant to the evolving domain of health promotion.

2. The evolving domain of health promotion

The Canadian Lalonde Report (1974) and McKeown’s study (1976) were the onset to a paradigm shift in public health calling for a “new public health”, moving away from the narrow biomedical view to a holistic and systemic view on people’s health. As a result the traditional behavior change models were no longer sufficient and needed to be complemented with a whole new set of responses not to educate but to promote and create social conditions favorable for health.

It took about a decade to organize the 1st Global Conference on Health Promotion at Ottawa (WHO 1986) and adopt a consensus that we needed to shift from individual foci to social determinants in public health. Notwithstanding situational changes in terms of socio-economic conditions across regions and their impacts on health driving the need for paradigm shift; and three decades after Lalonde (1974) and McKeown (1976); including Szreter (2002) the latter’s more recent critic who actually reinforces the social determinant view; we still struggle to get away from the stereotype deep-rooted mental models in many public health circles (WHO 2005).

However, today there is a global consensus on the need to go beyond the health sector. All sectors need to advocate (complementing health policy with health in all policies), invest (provide the means to act upon policies), build capacity (empower), regulate and legislate (enforce policies), and partner and build alliances (enhance public health practice).

Given the above aim and scope, health promotion is reaching far beyond the health sector and our traditional understandings and call for a whole set of new competencies. The evolution of health

promotion has progressed to extent that it now deals with social development as a health promoting intervention. However, in spite of this understanding, the theoretical bases of the discipline are still being established and building consensus on strategic orientations has faced tenacious resistance in the past decades (Nyamwaya 1997). An integrated approach to health promotion requires bringing diverse disciplines and sectors together to address health promotion challenges. Integrated planning and networking are mandatory in this context. Health promoters need to acquire competencies which go beyond the traditional health disciplines and extent to include media and communication skills, counseling skills, networking and partnerships skills, advocacy and activism skills which are necessary tools of the trade for today's professional in promoting social conditions favorable for population health.

As discussed by Rafael (2008) decades of efforts to introduce and advocate for health promotion concepts, implementation of these concepts in the service of public health has always been far from common practice. The longstanding biomedical and epidemiological traditions in public health policy added to inhibit health promotion approaches that incorporate the principles and themes of the Ottawa Charter (WHO 1986). Although there is increasing interest in the social determinants of health concept, yet education programs, governments' spending, media attention, and health sector activities lavished on lifestyle approaches to health promotion, while addressing root determinants of population health across sectors remain underserved.

Health promotion effectiveness depends on a workforce that is equipped with the core skills to implement current knowledge, yet flexible and adaptable to change (Barry 2008). The International Union for Health Promotion and Education (IUHPE) has identified workforce development and training as a key priority; and was the driving force to a consensus conference in Galway, Ireland to explore opportunities for collaboration in the areas of competency development, accreditation and training (Barry et al. 2009; Allegrante et al. 2009). There have been efforts to establish credentialing of practitioners in health promotion and credentialing of courses in health promotion, as well as, the identification of health promotion competencies in Australia, Canada, Scotland, UK, Estonia and The Netherlands (Shilton 2009; Morales et al. 2009). While significant challenges are encountered in terms of educational, practice, political, and resource contexts, it also creates an opportunity to build a flexible, relevant and comprehensive capacity building framework encompassing all those who contribute to health promotion.

3. Core competencies for health promotion

A comparison of various health promotion competency frameworks to date; which included the Australian Health Promotion Association Model (Shilton et al.2001; Shilton 2009), the European Competency Model (ASPHER 2010), the Galway Model (IUHPE 2009; Battel-Kirk et al. 2009; Dempsey et al. 2011), the Health Promotion Ontario Model (Hyndman 2007; Hyndman 2009), the NHS Scotland Health Model (Health Scotland 2003), the USA-based Health Educator **Competencies** Model (Gilmore 2005; AAHE 2006), the WHO-SEARO Model (WHO 2001), and the USA-based Public Health Core Competencies Model (CLAPHP 2010) shows notable differences between sets of competency frameworks. These differences may be attributable to differences in purposes, intended audiences, as well as contextual factors shaping the nature of health promotion practice. The "international" Galway model emphasizes following health promotion core competencies: (1) Catalyzing change through empowerment skills, (2) leadership skills, (3) assessment skills, (4) planning skills, (5) implementation skills, (6) evaluation skills, (7) advocacy skills, and (8) partnership skills. Not surprisingly showed the Australian and European models perfect alignment with the Galway model considering that the driving forces behind the Galway Conference reside in those regions. It is of interest that the WHO-SEARO model not only mirrors the "Galway model", it goes beyond the Galway consensus by including communication skills, social marketing skills, health promotion knowledge skills, and technological skills. Whereas the USA model did not include empowerment and partnership skills, and the Canadian model did not include evaluation and advocacy skills.

Further it is of interest to note that competencies in “theoretical foundations of health promotion” and competencies in “communication”, although recognized by various other regional frameworks, were not included in the Galway consensus. However, all frameworks embrace the definition of health promotion embedded in the Ottawa Charter (WHO 1986) as both the conceptual basis for and the desired outcome of health promotion practice.

Finally, the comparison revealed that the international consensus on health promotion competencies seem not to distinguish themselves from the widely recognized core public health competencies (CLAPHP 2010) except for the advocacy domain which is commonly recognized as a weakness among public health professionals (Chapman 2001).

However, caution needs to be observed in comparing these frameworks because competency domains consist of specific sets of skills and classification of these skills might differ across frameworks, therefore eventually resulting in the absorption, or the creation of, or overlap across domains. Unfortunately various competency framework models are still under development and a detailed account on specific skill sets are not available for several of them, thus preventing exploration of what makes health promotion competency domains distinct from corresponding public health competency domains.

4. Education in health promotion

Rivers et al. (1998) reviewed trends in professional preparation for health promotion and concluded:

“In none of the fields of professional education, continuous development, validation and accreditation, and evaluation were there a significant literature based on systematic evaluation, but weaknesses in practice were identified. A number of specific recommendations relating to the education and training of health professionals included: the importance of conceptual development and the capacity to reflect critically on practice; the value of efforts to bridge theory and practice; and the need to specify more clearly the health promotion role of professionals so as to facilitate the development of appropriate education and training” (p 260).

Given the controversy on the practice of health promotion, it is not surprising that education programs often continue to emphasize behavior change approaches to health promotion. Our underlying assumption in this paper, that there is scope for enhancing development of education programs to improve relevance of health promotion education programs to the need for health promotion practice, seems to be vindicated by the World Health Organization’s (WHO 2005, 2001, 2009) and the Institute of Medicine’s (IOM 2002) calling upon academia to develop education programs that formulate more extensive approaches to education that encompass the full scope of public health and health promotion practice.

Earlier work on public health curricula (de Leeuw 1997) established globally a strong correlation between the profile of those in charge and the characteristics of public health education programs. The question is pertinent though: “who is teaching in health promotion programs?”, and might provide an explanation as to why little progress has been made in the development of human resources with competencies relevant to current needs in health promotion practice. We can only underscore the importance of the argument put forward by Heward et al. (2007) that (education) institutional change is an essential but under-recognized function for capacity-building frameworks.

The internationally consented health promotion framework allows, to some extent, linking health

promotion functions, with tasks (action areas) and practice levels, it is acknowledged that health promotion tasks and practice levels are broadly defined and lines of distinction between them are not always clear. However, categories should allow for flexibility and be adaptable to a profession, which is still evolving and attempting to adapt to changing needs. At the same time, health promotion tasks need to be further clarified in terms of the skills required to undertake tasks, which then could inform enhancement of competency domains that are highly relevant to and distinct for health promotion practice.

Education programs in health promotion may vary in target groups, program levels (technical, undergraduate, graduate and continuous education programs) and the philosophy applied, assumable based on national identified needs. Therefore preparing professionals that might concentrate on behavior change or in contrast social change, while others would produce a workforce that could be employed across the spectrum of health promotion action areas. Recent work (Vichit-Vadakan & Van der Putten 2011), using the framework of health promotion action areas to assess curricula, shed some light on the current situation in workforce production (Figure-1) and seems to confirm earlier work (CLAPHP 2010; Wise & Signal 2000; Heward et al. 2007) pointing to the continued challenges faced in workforce development.

Figure 1. Distribution of Courses within Graduate Programs by Health Promotion Action Area and by Region

Figure 1 reveals that across regions emphasis in health promotion education programs remains on empowerment of individuals and communities, whereas reorienting health services, partnerships, supportive environments, and health policy received varyingly less attention. Further, among all regions, Southeast Asian programs exposed weakest attention for healthy public policy. Clearly, workforce development for health education and promotion in Southeast Asia (WHO region) remains heavily geared towards behavior change approaches. Similar patterns are observed in health education and promotion programs offered in socio-economic advanced countries. Southeast Asia was subject to profound contextual changes during the past decade in terms of social-political and economic transformations including multilateral efforts to strengthen the region at the global stage. Health inequities shaped by social determinants and enhanced by the challenges put forward by socio-political and economic change and globalization call for thinking differently about promoting health.

Health promotion remains an ill-defined domain for which it continues challenging to define a clear professional identity (ASPHER 2010; WHO 2009). Earlier discussions and viewpoints (WHO 2009, 2008, 2005; Chapman 2001; River et al. 1998) highlight that the key in creating leverage for a paradigm shift in educational institutes and their education programs is re-orientation and continuous capacity building among academia, since existing resource persons were perceived not to possess the required expertise. It is overdue for departments of health education and health promotion to become truly inter-disciplinary by opening the door for all relevant disciplines outside the realm of health sciences. The complexities faced in promoting health require thinking differently about preparing health promotion practitioners.

In summary, defining the concept of health promotion in ways that enable human resource development to develop a relevant competency framework remains a challenge. Overall various consultations did not succeed in creating a clear distinction for health promotion compared with general public health. In addition, academia involved in health promotion workforce development lack the expertise to fuel the needed paradigm shift. As a result health promotion education in South East Asia as well as socio-economic advanced countries remains heavily geared towards individual behavior change. WHO should continue to advocate for a paradigm shift and assist education institutes in exploring venues to enhance multidisciplinary faculty for health promotion.

5. The way forward

Development of organizational capability begins with those leading and populating these educational organizations. Earlier attempts by WHO-SEARO to boost health promotion education at national levels proved disappointing in moving away from the traditional mental models (WHO 2009). Sri-Lanka and Thailand stand out within the region both in terms of workforce production as well as health promotion practice, while Indonesia, although facing complex challenges, indicates potentials in settings-based health promotion (WHO 2009, 2001). WHO-SEARO has a pivotal role in fostering and guiding the ongoing dialogue within the region. An inter-institutional and interdisciplinary strategy would be worthwhile for WHO-SEAERO exploring to create a focal point within the region providing the critical mass required in fuelling the paradigm shift. Following suggestions can be made to bring about change:

- a. Adopt a consensually agreed framework that allow for linking health promotion functions, tasks, levels of practice, and the competencies involved. It is of importance to extent consultations beyond the traditional public health academia and professionals. So far, previous efforts focused on consulting only those actively involved in health promotion education. Ironically many experts represent the outdated paradigm and therefore might impede moving forward. To break through it will be needed to include experts from all relevant disciplines e.g. commerce and marketing, economics, law, mass communication, political science, social sciences, urban planning.
- b. Consider the degree to which consensus can be sought from a diverse group of respondents; relevant to health promotion goals, strategies, and action areas; while maintaining ethically sound and meaningful competencies.
- c. Based on identified core competencies, develop model curricula in health promotion for micro and macro level professionals in the South East Asian region; and re-orient fellowship programs with the aim to enhance efficiency and effectiveness in supporting capacity-building efforts.
- d. Education institutes and their departments with health promotion programs need to become truly multidisciplinary by involving discipline experts relevant to the paradigm shift in curriculum development and program delivery. A paradigm shift on education in health promotion could be fostered by carefully designed continuous education opportunities for academia involved in health promotion workforce production.

In absence of a single South East Asian education institute capable to implement the needed change, an inter-disciplinary and inter-institutional strategy coupled with a re-orientation of fellowship programs should be considered to foster desired development. Thailand; with its National Health Assembly providing a forum for dialogue among state and civil society agencies, its National Health Commission Office fostering healthy public policy, its Health Promotion Foundation funded by taxation policy, its National Health Security Office overseeing universal health coverage, its Health Systems Research Institute fostering evidence-informed policy decision-making; seems to offer an innovative professional context within the region for such strategy. Further, within Thailand few academic initiatives seem promising for following reasons: (a) openness to disciplines highly relevant to social determinants of population well-being; (b) the availability of international education programs; (c) the multidisciplinary and inter-institutional perspectives towards research; and (d) the development of these initiatives in absence of traditional departmentalization confining the domain. In addition, inter-regional strategies could be explored especially with the WHO Western-Pacific Region (WPR) with significant literature being generated from WPR, especially Australia. Therefore, mechanisms should be explored to stimulate and support those educational institutes motivated to develop and manage the desired change to arrive at relevant education in health promotion.

6. Conclusion

Behavior change models are no longer sufficient and need to be complemented with a whole new set of responses; including advocacy, partnership and policy development skills; to promote and create social

conditions favorable for health. This calls for reorienting the practice of health promotion, which in turn creates the need for enhanced professional competencies, and finally points to the development of education programs relevant to the need for health promotion practice. This poses challenges for educational organizations however these can be conquered if interdisciplinary and inter-sector dialogue is fostered.

Although these recommendations are aimed at enhancing health promotion in Southeast Asia, given the indications on the global situation in workforce production for health promotion, they may well be relevant to other regions facing similar challenges in boosting a much needed paradigm shift.

Investment in improved workforce production and health promotion practice could reduce competition for resources and provide return on investment over time. National and international alliances have a key role to play in mobilizing resources for both: competent human resources as well as effective health promotion practice in responding to today's public health challenges.

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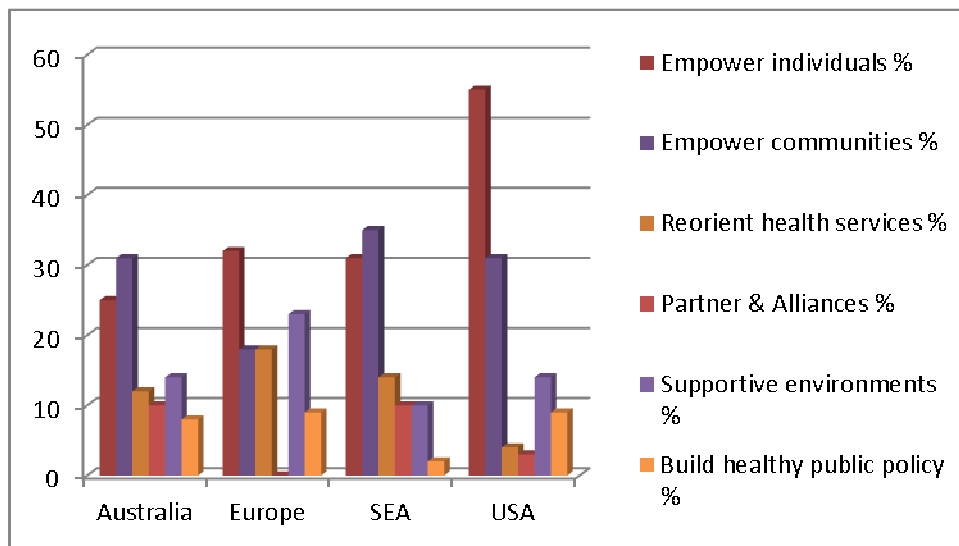
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Figure 1. Distribution of Courses within Graduate Programs by Health Promotion Action Area and by Region

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