European Dimension of Health Promotion

TWENTY YEARS OF CAPACITY BUILDING

Evolution of Salutogenic Training: The ETC 'Healthy Learning' Process

Gordana Pavleković,
Klaus D Pluemer,
Lenneke Vaandrager
et al (eds.)

1991 – 2011
etc
SUMMER COURSES

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Foreword and Acknowledgements

The idea to prepare this book to celebrate the 20th ETC-PHHP anniversary is best explained by a Latin proverb 'Verba volant, Scripta manent'. Twenty years is a long time, with many changes and challenges in both personal and professional lives of everyone. Since 1991, there have also been changes in the area of Public Health and in the development of a concept of Health Promotion, in the models applied to practice, and in the professionalization of this field, to mention a few. This evolution has influenced the decision by the ETC-PHHP partnership of the need to document the many lessons learned over the years and how this has been incorporated into the development of the ETC-PHHP programme. This book summarises the history and reflections of the founders, teachers and participants of this developmental process.

So, we as the editors and authors of this book would like to express the gratitude and thanks

To all authors, particularly founders of the ETC-PHHP programme – our friends and colleagues John Asthon, Selma Šogorić and Bengt Lindström for their contributions, not only in writing the papers, but also for their efforts in establishing and continuing the ETC network since 1991. Particularly Bengt Lindström who represents the enduring and continuing learning process represented through ETC.

To all authors – past participants, who sent us their reflections, observations and experiences following their attendance at one of the annual summer programmes. The list of names is long but this book belongs to them and their contribution is the best indicator of how the network is still alive and effective.

To our colleagues and friends for many years who are sharing our visions and give a great support in future development. Special thanks to Michel O'Neill for his valuable comments on papers prepared by past participants and newcomers, with support from Elisabeth Fosse and Lynne Kennedy.

To all those who made the great efforts to prepare this book in a very short time, especially Alma Šimunec Jović and Klaus Pluemer. They tried to combine personal responsibilities and professional duties in order to make the book visually attractive and professionally interesting.

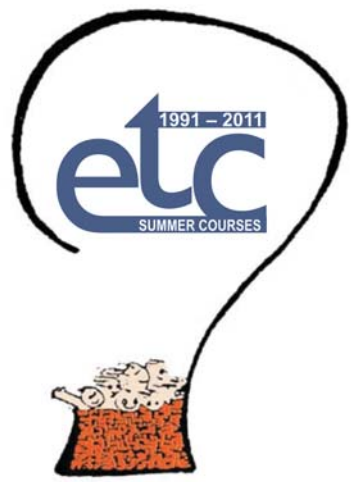
To the Ministry of Foreign Affairs and European Integration, Republic of Croatia, for their financial support to publish this book.

The purpose of this book is to illustrate key highlights and provide a 'snap shot' of the ETC-PHHP development, the experiences and the learning processes that have contributed to the past twenty years in Capacity Building in Health Promotion. This book is dedicated to all present and future colleagues who have visions and enough enthusiasm and creativity to face with a challenging future.

Editors, Zagreb, 2011

Part 1

ETC-PHHP Experiences 1991-2011



ETC-PHHP – Short Story about History

Paolo Contu

The WHO Health for All Targets adopted in 1984, as a common Public Health Strategy for the European Region, has increased the need for a reorientation of Public Health Policy training and education in Europe. In 1987 the WHO Regional Office for Europe started a joint project with the Association of Schools of Public Health in European Region (ASPHER) to investigate the possibilities of developing a new Public Health Education Program. An initiating meeting was organized in 1990 in Gothenburg, and the European Training Consortium in Public Health and Health Promotion (ETC-PHHP) was founded by four schools of public health: Gothenburg (Sweden) – Liverpool (UK) – Valencia (Spain) – Zagreb (Croatia).

Box: Venue and Titkes of the ETC Summer Courses 1991 to 2011

ETC-PHHP Continuous Summer Courses since 1991

1991 Valencia: Healthy Lifestyle
1992 Gothenburg: Promoting the Health of Children and Youth in Europe
1993 Valencia: Settings for Health Promotion
1994 Liverpool: Strategies for Health in Europe
1995 Prague: Networks and Collaboration for Health Promotion
1996 Prague: Innovation in Education and Training for the New Public Health
1997 Cagliari: Health Promotion and Research
1998 Wageningen: Participatory Methods in Health Promotion
1999 Liverpool: Health and Health Care
2000 Zagreb: Back to the Future: From Principles to Practice, from Practice to Visions
2002 Valencia: From Public Health to New Public Health and Health Promotion
2003 Cagliari: Community Participation and Intersectoral Collaboration*
2004 Galway: European Perspectives on Promoting Health and Well-being*
2005 Perugia: Rethinking Health Promotion in a Changing Europe*
2006 Zagreb: Sailing across new seas – Capacity Building for Health Promotion Action*
2007 Wageningen&Dusseldorf: Reducing Health Inequalities – Evidence for Community Action*
2008 Bergen: Health in All Policies*
2009 Cagliari: Exploring Salutogenic Pathways to Health Promotion
2010 Magdeburg: Building Civil Society for Health*

**in collaboration with EUMAHP*

1991-1995

The course, held each July/August, consisted of 3 weeks of residential work, including lectures, field visits and the design, mentored by a tutor, of an individual project to be discussed at the end of the course. Tutors and students share accommodation, main meals and often leisure time.

An agreement signed by the network institutions defined mutual commitments and

decision making procedures, but the formal structure was very light, and the cohesion was assured more by the personal relationships and motivations than by the formal obligations.

The network was managed under equality basis, with decisions and roles shared among all partners. This was also signified by the decision of involving all partners in hosting the course. The first summer course was planned for 1991 in Zagreb, but, because of the war, it was moved to Valencia, and the next four ones were run in Goteborg, Valencia, Liverpool and Prague.

The network was open to involve new partners: during the first five years three new partners joined the group: Prague in 1994, Cagliari and Wageningen in 1995. The involvement was triggered by the participation in the summer courses, and fostered by common research projects. For example Wageningen and Cagliari share a research project with Liverpool and Valencia before joining ETC-PHHP.

A number of 20-30 students attended the courses every year by coming from different professional fields (health promotion, public health, health care, education, social work. research, policy, management) and levels (post graduate students, professionals, researchers). Students from East-Europe, who participated in these years, particularly from the Baltic countries, were facilitated by special funding programs.

1996-2001

The new partners Prague, Cagliari, Wageningen, mainly hosted the annual summer course in these years. Zagreb was selected in 1999, but the course was moved to Liverpool because of the Kosovo, and again in 2000.

In 1997 the course was evaluated and accredited by ASPHER, and in 2000 integrated with a conference involving health promotion leaders and former students to celebrate the tenth anniversary.

The contents and the methods were designed according to experience of the first years in order to combine lectures, workshops and project preparation towards a common aim.

The common research programs included student's exchanges.

After the growth of the first years some problems arose challenging the network team.

Some of the original partners started to be less involved, because of changes in persons or policies. Some of the new leaders did not share the original vision, and this sometimes created misunderstandings and conflicts, particularly when new teachers jumped in the course without any experience in it. We learned that the specific style of ETC-PHHP requires not only general competencies, but also a specific experience in our summer course.

Three weeks of summer course required a relevant allocation of time. On the other side the availability of Internet communication made possible to move the contents of the first week to a distance phase.

The recruitment of students was limited to a narrow context around the networks and there was a clear need for new “markets” and partnerships.

The preparation of the individual project had gained the main role in the course, weakening the sense of teamwork and the interest for the other learning activities.

2001-2006

Also because of these difficulties the 2001 course was not run and a planning meeting was organized at the end of the year, with the participation of Dusseldorf as new partner:

- the course was restructured into two weeks with a distance preparation;
- the project became a team one in order to foster the skills in international design and teamwork;
- the collaboration with new partners became a main aim.

Since 2002 the EUMAHP Consortium joined the organizational team of the summer school. EUMAHP was founded in 1998 with support of the European Commission as part of the public health action program to develop a core curriculum for a Master in Health Promotion on a European level.

The 2002 course (Valencia) tested successfully the new course format and was linked with a simultaneous training in Lisbon. Tutors and students from EUMAHP participated in the 2003 course (Cagliari) exploring the opportunity for a wider collaboration.

In 2004 (Galway) and 2005 (Perugia) the summer course was held in collaboration with EUMAHP and hosted by EUMAHP partners.

The 2006 course was again hosted in Zagreb, always in collaboration with EUMAHP.

In 2003 and 2005 parallel courses in Italian language were organized to facilitate the participation of local students and professionals. In 2004 a Portuguese course was held in Lisbon with the same format and in the same period, with a common final presentation of the projects by tele-conference.

Perugia and Bergen, that, like Magdeburg, have always been present with tutors since 2004, signed the ETC-PHHP Agreement in 2006. Since 2005 Valencia and Prague did not participate more in the summer courses.

The course, conducted at post-graduate (Master) level and 8 ECTS of formal study. The number of participants was always around 20-30.

2007-2011

In 2007 the summer course was shared between Wageningen and Dusseldorf, in 2008 it was held in Bergen, in 2009 again in Cagliari (with a parallel Italian course, and an overall number of 78 students), and in 2010 in Magdeburg (with the participation of a group of German students). Both in Cagliari and in Magdeburg the students of the local courses in health promotion attended the summer school. In 2011 the course,

planned in Zagreb, will begin with a three days symposium attended by former tutors and students.

The University of Girona, Spain and Glyndwr, Wrexham, Wales are going to join the network, and other potential partners are developing contacts.

Since 2009 ETC-PHHP is involved as partner in the CompHP project aiming to define competencies, curricula and accreditation system for health promotion.

ETC-PHHP Network

The European Training Consortium in Public Health and Health Promotion (ETC-PHHP) is the only working group that continued to work on the initiatives started by the ASPHER and the WHO/EURO. After the initiating meeting in Gothenburg, other working groups did not organize the training courses.

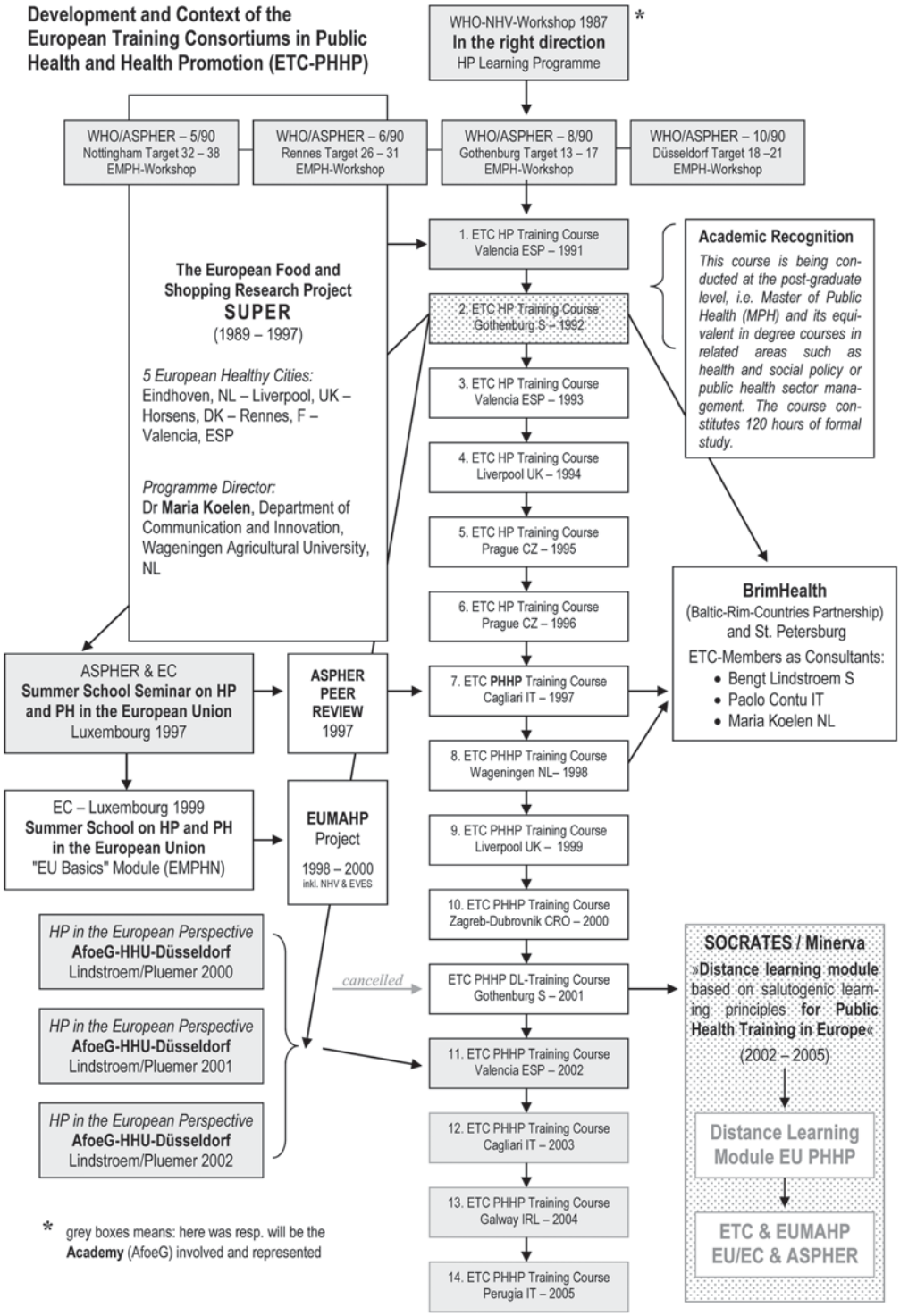
During the last twenty years ETC-PHHP has organized an annual summer school focused on developing practical and theoretical tools to enhance health promotion strategies in Europe. Since the first summer school in 1991, more than 500 participants from 32 European and 12 non-European countries have participated.

ETC-PHHP survived and grew because of its ability to adapt itself to internal and external changes.

Some of the founders become less active, but the new partners took over to them, and new members are ready to join. All new partners join the consortium with a roadmap including common project and the participation to one or more summer courses as students and / or observers. This assures a full understanding of the network's vision and methods and allows evaluating the implication of the commitment. This process, emphasizing more the personal involvement and motivation than the legal agreements, has been very effective in team building creating a synergic group of tutors able to include new members. With this approach the commitment of the institutions depends mainly on its individual member, and on his role and influence in his or her organization.

The course, without changing the original principles, has been adapted to new needs and assets. The first courses were more oriented to introduce professionals, often with "old style" training to the new health promotion approach. After 20 years most of participants come with a health promotion background, although at different levels, and the main emphasis have move to enabling people to collaborate in an international context and to design international programs. The development of Internet communication allowed to shorten the residential course by introducing a distance part, to make information available on the website, to facilitate the exchange among students and tutors...

The Consortium was always open to projects and collaboration, both as supportive context for projects involving some of the partners, and as group for external partnerships (EUMAHP, COMHH…). Although the financial resources are mainly



Prepared by Klaus Pluemer

ETC Database 1991-2010

Statistics Participants

Variables	Number
Number of Particpants	475
Countries	44
External Lecturer & Tutor'	107
Female (74,7%) / Male (25,3%)	355 / 120
1st decade (44,3%)/2nd decade (55,7%)	208 / 261
1st decade participants per course	21
2nd decade participants per course	29

Year/Participants (469

1991 Valencia	17	2000 Zagreb	16
1992 Gothenburg	19	2002 Valencia	18
1993 Valencia	22	2003 Cagliari	45
1994 Liverpool	16	2004 Galway	27
1995 Prague	28	2005 Perugia	35
1996 Prague	24	2006 Zagreb	27
1997 Cagliari	37	2007 Wageningen & Dusseldorf	27
1998 Wageningen	14	2008 Bergen	27
1999 Liverpool	15	2009 Cagliari	30
		2010 Magdeburg	25

Countries & Participants

Azerbaijan	1	Latvia	8
Austria	8	Lithuania	23
Belgium	4	Luxembourg	1
Bosnia-Herzegovina	1	Macedonia	2
Bulgaria	1	Malta	1
Canada	12	Nepal	1
Colombia	1	The Netherlands	28
Croatia	25	Norway	32
Czech Republic	20	Poland	6
Denmark	10	Portugal	9
Estonia	11	Republic of Korea	2
Finland	22	Romania	9
France	1	Russia	2
Germany	30	Serbia	1
Greece	6	Slovenia	8
Hungary	6	South Africa	1
Iceland	3	Spain	35
Ireland	15	Sweden	25
Israel	1	Switzerland	4
Italy	62	Turkey	2
Japan	2	U.S.A.	1
Kosovo	2	United Kingdom	30

Prepared by Klaus Pluemer

collected through student's fees, the consortium was often able to obtain additional financing, particularly to facilitate the participation of students, through national and European funds.

A number of challenges need to be taken into account.

The audience for the recruitment of participants is still too narrow, too dependent on ETC-PHHP and EUMAHP institutions. An additional problem is represented by language limitations with a huge number of students and professionals unable to work in English, as shown by the wide participation in courses in national languages. The world economic crisis worsened the problem reducing the amount of money for bursaries and travels. The linkage with the broader IUHPE strategy for capacity building and the involvement of partners in new areas could be a good answer to this challenge.

The lack of a formal structure enabled to sign collective agreements, although appropriate for flexibility, can represent a limitation in visibility and funds collection. Important opportunities can be open by the involvement in the new IUHPE strategies for capacity building.

Health Promotion Philosophy and Theory

Maria Koelen, Bengt Lindström

What is Health promotion and why is it there?

So many years after its first description, 25 to be precise, it seems to be overdone to explain what health promotion stands for. Yet, this is where we start. The origin of the health promotion movement in fact relates to a shift in thinking about health and the advancement of health. For centuries, health was defined in terms of the absence of disease and physical disability. Somewhere in the mid of the 20th century this narrow idea gradually shifted towards a broader, holistic point of view. The Canadian Minister of Health, Lalonde, published a paper in 1974 which has been very influential in this shift in thinking. He pointed out that health is not only influenced by biological factors, but that human behaviour, the social and physical environment, and the organisation of health care were pivotal as well. Today we define health in terms of physical, social, spiritual and mental wellbeing, which enables people to lead an individually, socially and economically productive life. Health is seen as a resource for everyday life, not the objective of living.

The concept of health promotion was born at the first International Conference on Health Promotion in Ottawa, Canada (1986). Health promotion was defined as "the process of enabling people to increase control over, and to improve, their health". It became evident that the advancement of health had to go beyond medical care and lifestyle interventions, and that it had to be supported by structural measures such as legal, and regulatory ones. And, as formulated in the Charter, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organisations, by local authorities, by industry and the media.

Health promotion is based on five principles (Ashton & Seymour, 1988): (1) It actively involves the population in everyday-life settings. (2) It is s directed towards action on the *causes* of ill health. This means that the focus is on prevention rather than on cure, but it also recognises the necessity of a broad approach, that is, that action should be directed at the social and physical environment. (3) Health promotion uses many different approaches, including education and information, community development and organisation, health advocacy and legislation. (4) Health promotion depends particularly on public participation, referring to the notion of community participation. Finally, (5) health professionals have an important part to play in nurturing health promotion and enabling it to take place.

An important goal of health promotion is to make it easier for people to make healthy choices. Several barriers, both within individuals and within their physical and social environment, can hamper the possibilities to make such healthy choices. Health promotion therefore works on improving the capacities of individuals, but also on

improving the social and economic conditions and the physical environments in which people live (Nutbeam, 1998).

The fact that health promotion is practiced and studied now for 25 years may give the impression that there is a solid theoretical base in the meantime. This however is not true. In fact, many of us are still looking for theoretical underpinning and operational definitions of key concepts. The biomedical or pathogenic approach, where health is generated through the elimination of risks for diseases, is still the dominant paradigm. Much of the research has been limited to risk and health-related behaviour. Health promotion philosophy however, focuses on health rather than on disease. We therefore in the remainder of this paper will elaborate on a different approach, which in our opinion contributes to the development of a theoretical base: Salutogenesis. Contrary to the pathogenic approach, Salutogenesis focuses on assets and resources for health and health promoting processes (Antonovsky1979; 1993). We first discuss the impact of this approach on thinking about health and health enhancement. Subsequently we provide a theoretical base for empowerment, one of the key outcomes of health promotion. In doing so we strongly rely on our previous work in this area (Koelen & van den Ban, 2004; Koelen & Lindström, 2005; Lindström & Eriksson, 2010; Koelen, 2011).

From the river of health to the river of life

Traditionally, the difference between the biomedical model and public health has been described through a metaphor of a river. The following stages are described, moving up the river: (i) cure or treatment of diseases; (ii) health protection/disease prevention; (iii) health education, and finally on top of that (iiii) health promotion. The latter holds a rather different perspective, relating to resources for health and life and not primarily risk and disease. All approaches ultimately strive to improve health, but out of different perspectives. This is a classic image called *The River of Health* (see Figure 1), where "the down river stream" is focusing on processes where the risk exposure already may have caused damage (cure, protection, prevention and often health education).

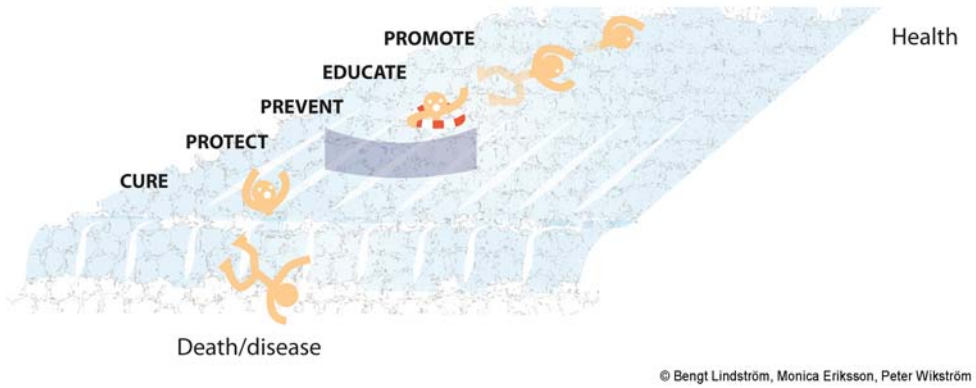


Figure 1: The River of Life

The river of health is a simple way to demonstrate the scene of actions for health. The health concept in the biomedical paradigm is constructed from the understanding of disease, illness and risks. This classic image explains the difference between care, protection, prevention and health education, yet it opens for health promotion. However, in health promotion we bring the focus upstream, finding resources and initiating processes not only for health but also for wellbeing and quality of life.

Contrary to a pathogenesis focus on disease generation, the salutogenic perspective focuses attention on health generation, on the direction towards health, and the ultimate objective of health promotion activities is to create prerequisites for a good life. Perceived good health is a determinant for quality of life. To explain the shift from a pathogenic to a salutogenic paradigm, the metaphor of the river needs to be different. This is reflected in *Health in the River of Life* (Figure 2; Eriksson & Lindstrom, 2008). Here the river flows vertically across your view. Along the front side of the river, there is a waterfall continuously following the stretch of the river, meaning wherever you are there is always a possibility to encounter risk and disease. However, the main flow and direction of the river is not down the waterfall but going vertically in the direction of life. At birth, we drop into the river and float with the stream and over life we learn how to swim. Some are born at ease where the river flows gently, where there is time to learn, where one can float and the prerequisites for life are good with many resources at disposal, like born in a welfare society. Others are born close to the waterfall, at dis-ease, where the struggle for survival is difficult and the risk of going over the rim is much greater. The river just like life is full of risks and resources, however, our outcome is based on learning through our life experiences thus acquiring an ability to identify and use the resources necessary to improve our options for health and life. The health process is a learning process where we reflect on what will create health and what are the options for life and improves QoL.

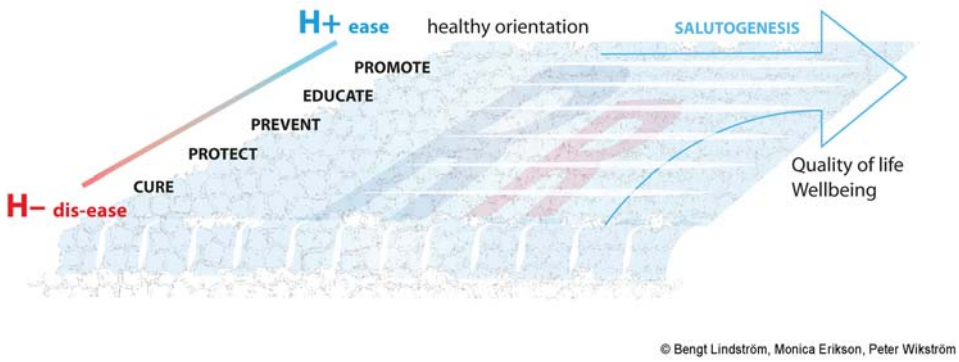


Figure 2: Health in the River of Life

Empowerment is the objective, but what does it mean?

The ability to identify and use the resources necessary to improve our options for health and life very much resembles the main objective of health promotion: empowerment. Empowerment is considered to be the process through which people gain greater control over decisions and actions affecting their health (Nutbeam, 1998). Much of the theoretical underpinnings of empowerment are based on the work of Paulo Freire (1973) who developed his ideas in literacy programmes in slums in Brazil, under the title "the pedagogy of the oppressed". Since then, the concept has been examined in diverse academic and professional disciplines, amongst others in sociology and educational sciences. Empowerment is often linked with social systems, communities, and social change (e.g. Bracht et al., 1999). Yet, in spite of extensive research and several programmes that aim at empowerment, there are many interpretations of the concept, and there is no unequivocal operationalization. Because empowerment is more of a principle than a solid theory, Eriksson & Lindström (2005) suggested that the salutogenic approach of Antonovsky (1979; 1987) could form a theoretical framework. The salutogenic perspective focuses attention on health generation as compared to a pathogenesis focus on disease generation. The perspective introduces two fundamental concepts: the general resistance resources (GRRs) and the sense of coherence (SOC). The GRRs are biological, material and psychosocial factors that make it easier for people to perceive their lives as consistent, structured and understandable. They help people to move in the direction of positive health. Typical GRRs are money, knowledge, experience, self-esteem, social support, culture, intelligence, traditions, and ideologies. If people have such resources at their disposal or available in their immediate surroundings there is a better chance for them to deal with the challenges of life. GRRs open up the possibility for people to construct coherent life experiences. More important than the resources themselves, however, is *the ability to use* these resources. This is the meaning of the second and more generally known salutogenic key concept: the sense of coherence (SOC). The SOC is described by Antonovsky (1979) as the extent to which one has a pervasive, enduring, though dynamic feeling of confidence that one's internal and external environment is predictable and that there is a high probability that things will work out as well as reasonably can be expected. Thus, SOC refers to a person's capability to see that one can manage any situation, independent of whatever is happening in life. The general resistance resources assist the individual in developing a strong sense of coherence. SOC and GRR focus on (the availability of) resources and on the (learned) ability to deal with and use those resources. Based on these elements of salutogenic thinking, we define individual empowerment as: a process by which people gain mastery (control) over their lives, by which they learn to see a closer correspondence between their goals and a sense of how to achieve these goals, and by which people learn to see a relationship between their efforts and the outcomes thereof.

Towards a deeper understanding of empowerment

Concepts that can help to further understand empowerment and which can contribute to the operationalization originate from amongst others, attribution theories, control theory, social learning theory, and self-determination theory.

The first concept is *locus of control*, which is defined as a generalised expectation of the correspondence between an individual's acts and the outcomes (Rotter, 1966). People who see outcomes (the things that happen to them) as a result of their own behaviour are considered to be internals. People who see things that happen to them as a result from external forces are considered to be externals. Related to health, we refer to *health locus of control*. Internals feel that they can influence their own health by changing their 'risky' behaviours into more healthy ones. Externals on the other hand, have the idea that own their behaviour does not affect their health. Their health status is destined by some outside forces, such as 'the will of God' or 'it is in the hand of doctors'. Locus of control is considered to be a *personality trait*, which means that it is relatively stable over time and situations. It is generally assumed that people with an internal health locus of control have better health habits, are more likely to perform health promoting behaviours, and consequently have better health status, than people with an external locus of control.

A second, related concept is that of *Learned Helplessness* (Seligman, 1975). Learned helplessness refers to a general lowered state of functioning, stemming from experiences with uncontrollability. If people find themselves in a situation in which there is no good connection between the behaviour and the results of that behaviour, they feel a lack of control. Consider someone who tries to loose weight and follows a diet but does not succeed either to loose weight or to keep up the diet. If this happens once, it may not be a problem: just try harder next time. However, if this result is repeated, it will be accompanied with a so-called giving up response. So, people trying to loose weight or trying to stop smoking become prone to "stop changing" or to "stop stopping". Learned helplessness may have consequences for other behaviours as well. "If I did not succeed to stop smoking I probably also will not succeed in loosing weight". Learned helplessness somehow is comparable to external locus of control, but here it is not a personality trait but a *'state'*. This is an important difference, because personality traits are relatively unchangeable. States though, however difficult it may be, are more vulnerable to change.

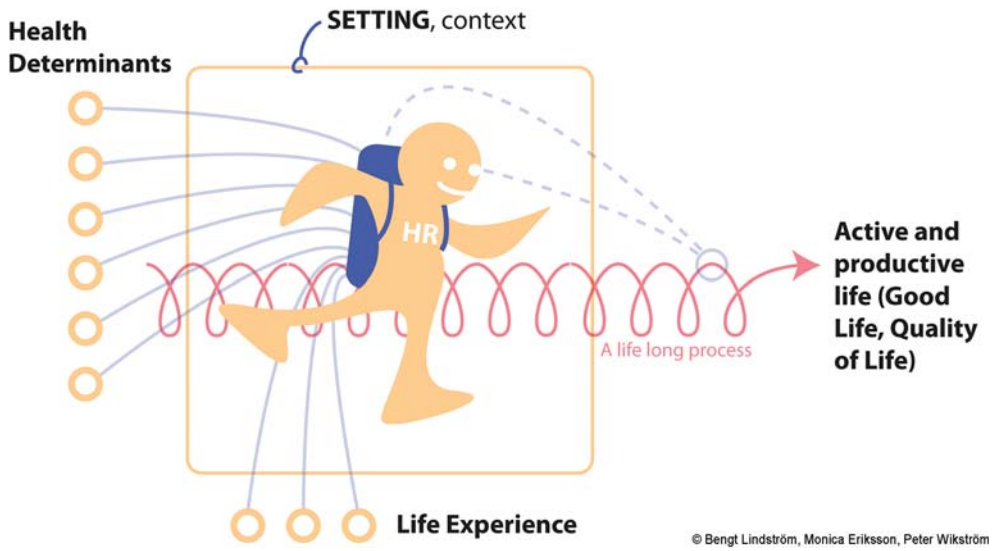
A third and again related concept is that of *perceived self-efficacy* (Bandura, 1982), which is defined as people's belief in their capability to organise and execute the course of action required dealing with prospective situations. It refers to the perception of individuals about how easy or difficult it is to perform a specific behaviour, and their perception about whether they are able to perform the required behaviour or not. Feelings of efficacy are primarily based in what we call performance history. Consistent success experiences lead to high perceived self-efficacy, consistent failure leads to low perceived self-efficacy. Self-efficacy thus also is a state, as is learned helplessness, but generally it is behaviour specific. Someone who fails to stop smoking may still feel capable to reduce weight.

A fourth aspect, which can influence feelings of empowerment, is that of *outcome expectations*. Outcome expectations refer to a person's estimate that a given behaviour indeed will lead to the expected outcomes (Bandura, 1982). So, for example, if I change my diet will it indeed lead to reduced weight? And will it indeed increase my physical condition? Outcome expectations are not necessarily based in direct personal experience. If the outcome expectation is low, individuals are less willing to put the effort in performing behaviour. Outcome expectations do not have an overall negative effect. For different behaviours and even in different situations, the expectation may be either high or low.

Control as the core concept

The concepts described to understand empowerment have a common ground in feelings of control, and indeed, enabling people to increase control over their health and factors influencing health is a main objective of health promotion. People feel in control if they experience a correspondence between their cause of action and its outcomes (i.e. a positive effort-results relation; success experience). People who do not experience such a positive relation (e.g. "I put a lot of effort, but it does not lead to the expected outcome") experience loss of control. Low outcome expectations, low self-efficacy, and learned helplessness all are based on low control experiences, whereas their counterparts are based on successive success experiences, hence high control. Generally, a lack of control negatively influences feelings of empowerment, whereas feelings of being in control positively influence feelings of empowerment, which in turn affects both people's mental and physical well being.

An important difference between the concepts is their stability, and more specifically, the extent to which they are changeable over time. The stronger they are based on consistent success or failure experiences, the more stable they are. For health professionals the challenge is in influencing the negative expressions of the concepts.



Low outcome expectation may be based on a single negative experience, or it may be just an idea, and it is relatively easy to change. Low perceived self-efficacy mostly is behaviour specific, and primarily based on a longer standing negative performance history. It is therefore more difficult to change, but providing clear instructions about how to perform the advised behaviour can influence it. Several studies show that higher levels of perceived efficacy lead to choices for healthier behaviours than lower levels of perceived self-efficacy.

Learned helplessness and locus of control are more generalised feelings of lack of control, and are rather stable over time. In fact they very much relate to Antonovskys' ideas about Sense of Coherence; also relatively stable in time. The negative expressions discourage people from taking action because they feel it is out of their own control, but the positive expressions stimulate to take action. Although difficult, the negative expressions can be changed. Much experience in this regard is gathered in so-called reattribution programmes, which aim to help people to regain confidence and feelings of control. A step-by-step approach is common in reattribution programmes, initially setting targets that are easy to reach. For example, an obese person may have to lose up to 30 kg of weight. This is a high target, and usually one will not succeed. Therefore, it would be more helpful to have targets set that are easier to reach, e.g. an initial weight loss of five kg. This increases the chance of success, which increases the motivation to continue, especially if successes are followed up by additional successes. The most important thing is that people feel that certain outcomes are under their personal control thereby increasing the chance that one will persist in that behaviour.

3rd ETC-Course Valencia, 1993

Conclusions and discussion

We have discussed health promotion and empowerment and proposed to approach these concepts from a salutogenic perspective. General resistance resources (GRRs) and sense of coherence (SOC) could "empower empowerment" in a scientific sense, and give it a theoretical base and a clear structure. Moreover, it gives the opportunity to unravel some of the factors influencing individual empowerment. We provided some suggestions as to how these factors can be influenced. Strategies for change in fact refer to the availability of resources and the (learned) ability to use them.

Health promotion professionals are expected to play an important role in enabling people towards empowerment. They should provide support and options that enable people to make sound choices, that is, to foster the assets and resources for health and to enable people to use these in a healthful way. In fact this last aspect is also referred to as *health literacy*. Health literacy is assumed to be critical to empowerment. It represents the cognitive and social skills which determine the motivation and ability of people to gain access to information, and to understand and critically use this information in ways which promote and maintain good health (Nutbeam, 1998). By improving peoples' access to health information and their capacity to use it, and to use it in a critical way, health professionals can facilitate successes and thereby the process of empowerment.

We are aware that 'enabling people towards empowerment' may be more easily said than done. Health professionals are expected to act as a catalyst, for example by providing information on health and by facilitating skills development, but there are at least two complicating factors. Firstly, as Pease (2002) argues, there seems to be a paradox in being a professional and being committed to empowerment. An essential part of a profession is the profession-specific knowledge base. Professionals are supposed to be experts, but by using their 'power of expertise' they can dis-empower people and thus subvert the actual goal of empowering. A second complicating aspect is that, in order to empower people, professionals themselves have to be empowered as well. In fact, all the aspects influencing empowerment are applicable to professionals as well.

As we argued before, up to now there is no clear theoretical framework supporting the principles and values of the Ottawa Charter. Worldwide, a lot of health-research is going on, but most often it focuses on illness and on the individual and societal risks of disease and disability. Measures of effectiveness of interventions often focus on short-term changes in knowledge, attitudes, and individual behaviours, and on health outcomes such as reduced blood pressure and cholesterol levels. In fact, in research, policy, or practice, health is considered from the perspective of illness and looking for individual and societal risks of disease and disability. This implies that the dominant paradigm is biased by the biomedical pathogenic tradition. This apporoach has been very useful, but today we face new circumstances and new challenges (Koelen, 2011). In our opinion, we can make a good step forward if not disease but health is at the centre of research. People do not just have problems, do not just run

the risk of becoming ill or impaired, and if we *focus* our research on problems and risks, we only will *find* problems and risks. The salutogenic approach is not looking for risk-factors and causes of disease, but is looking for assets and resources in individuals and their social and physical environment, assets and resources that contribute to good health. This will lead to new insights and new theories, and helps us to overcome the sub-optimal effectiveness of the biomedical approach. Thus, by putting health at the centre of our research, we can make a real step forward.

First version from July 2010

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ETC-PHHP Innovative Teaching and Learning Methods:

Experimental Learning Simulates Partnership Working for Health Promotion

Lynne Kennedy, Lenneke Vaandrager

Key learning points

- Summer school students experience cooperative learning with people from diverse professional and cultural backgrounds and this leads to genuine experience in the original WHO principle for *intersectoral collaboration*
- Effective group learning is based around the principles of using the power of the team to encourage students to accomplish the learning objectives, with an emphasis on *process*;
- Through country presentations students exchange information about the different social and cultural 'nuances' in the various countries and how this impacts on health promotion possibilities and solutions;
- Learning is both formal and informal;
- Tutors practice what they preach by trying to create positive conditions for healthy learning

Introduction

Health Promotion is based on a number of core principles such as community participation and intersectoral collaboration. Through the Summer school we apply these principles both in the way the programme is organised and also delivered to ensure that participants have the opportunity to enhance their ability in understanding, discussing and applying health promotion principles and methods in a concrete or practical context. How is this achieved? A key activity within the two, formerly three-week intensive schedule is the 'group project'. Here students are divided into small project groups, involving participants from a diverse range of countries and social and cultural backgrounds, to develop a collaborative research or project proposal based upon the specific theme of that years summer school and of course integral to this are the World Health Organisation's (WHO) key principles and strategies of health promotion. Twenty years of ETC experience suggests using multi-disciplinary and international student-centred problem based scenario, based upon the pedagogic principles of cooperative learning (see e.g. Hernandez, 2002; Morse, 2007), is invaluable in simulating the experiences inherent to partnership

and interagency working. It is this combination of learning activities that enhances knowledge, understanding and core skills in Health Promotion practice. This chapter will examine the most important elements of this approach.

Cooperative learning as a pedagogic approach

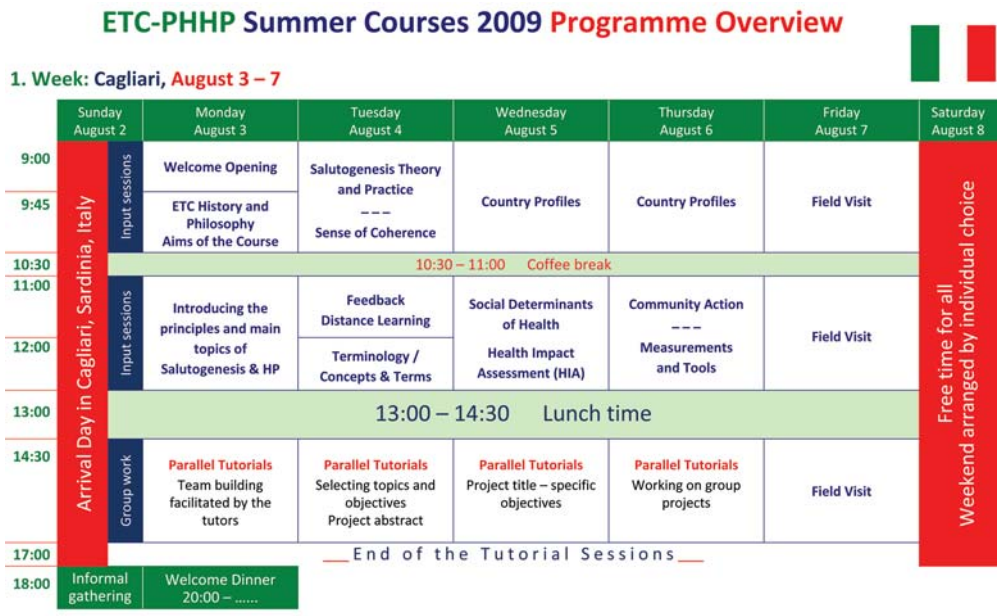
Cooperative learning or team learning is about the creation of cooperative structures, as a part of the course design, that is effective in promoting high level thinking and learning in a group. Working together on one project enables students not only to cross boundaries between theory and practice and between disciplines, but also between the different social and cultural contexts in which learning (about health promotion) takes place. Effective group learning is based around the principles of using the power of the team to encourage students to accomplish the learning objectives (Hernandez, 2002). One study (Morse et al, 2007), evaluated an interdisciplinary research project involving a team of PhD students. Based on their evaluation and a comprehensive review of the pedagogic literature they identified 'bridges and barriers' for interdisciplinary research on three levels: the individual or personal level, the disciplinary level and the programmatic level. Interdisciplinary research and cooperative learning can be enabled or challenged by individual personalities, disciplinary distinctions, and programmatic design. Proactive planning and continued reflection on the process of integration throughout the project helps to navigate through many potential barriers and identify other prospective bridges. The project work in the summer school is based on these recommendations.

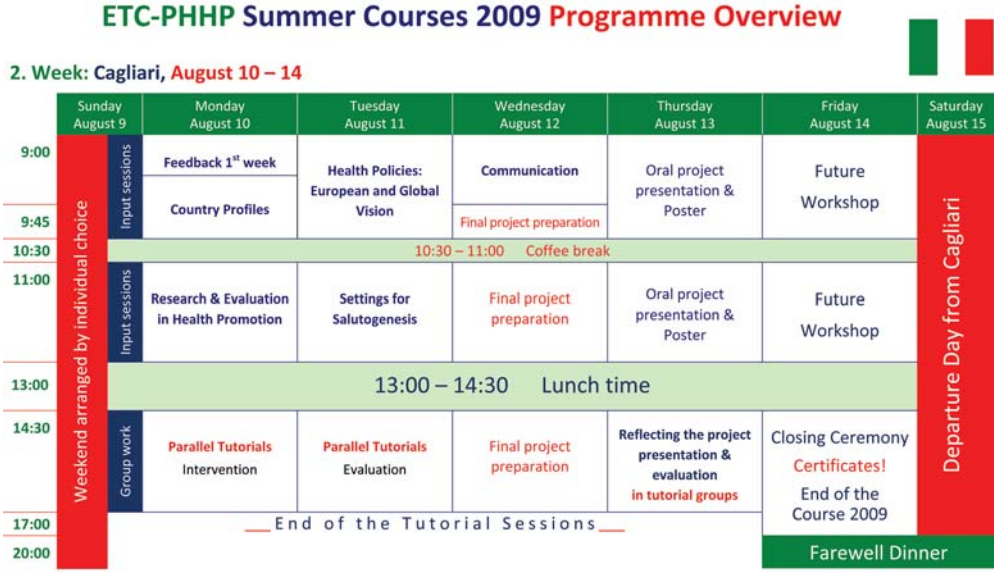
Structure and Summer school themes

As mentioned, for effective collaborative learning a structure is provided. The structure adopted by the ETC summer school has evolved over time. In the early days the summer school was held over 3-weeks, with an emphasis on information giving. Now 21 years on, experience has shown that the most valuable and effective learning takes place between participants and tutors in a collaborative problem based scenario. The current 2-week format and structure has been in place for over ten years now (for example see Box: 1) with much of the information giving and background learning delivered through the distance learning element.

The Summer school is always based on a special theme such as *'Health in all Policies'*, *"Coordinated action for health"* or *"the life course perspective"* (see box 2: themes). The programme starts with inspiring key note sessions followed by core or generic themes around Health Promotion, such as "Review of the principles of Public Health and Health Promotion"", "evidence based Health Promotion", "Research methods for Health Promotion", or "The challenges of practice: participation, intersectoral action, communication".

The formal learning, keynote and generic lectures, are designed to inform participants of key principles and outline key information relating to the chosen theme. The formal





session is also used to introduce the group project work, by outlining recent or current knowledge of contemporary health promotion issues and themes. All groups produce a final international project proposal around the special summer school theme so there is also a clear goal to work to (see practical arrangements). In preparation for the face-to-face part of the Summer school all students are required to undertake the distance learning element and must write and submit a written report, combining information with theoretical discussion, within the context of participants own prior experience or the social and cultural contexts of their country of work.

Distance Learning

The distance learning as described in another chapter in this book is critical in preparing students for the practical or group work element, ensuring all students have common baseline knowledge necessary to engage in productive dialogue on the subject matter; thus facilitating active participation and engagement in the collaborative learning process and achievement of the overall learning objectives.

Box 1: Distance Learning

A special part of the summer school includes the distance learning.

Distance learning activity consisting of three activities:

1) reading background literature;

2) writing a report; and

3) preparation of country profile, i.e. a joint oral presentation from participants coming from the same country.

During this distance learning phase the participants improve their abilities in critically reviewing the main Public Health and Health Promotion trends in their local and national context and in a wider European and global perspective. They describe and discuss health and health promotion programmes in their own countries as well as the main challenges for public health, and they critically assess the relation between these challenges and health promotion principles.

Students receive feedback on their essay from their tutor during the distance learning period and final comments during the first week of the course. Although it is not formally evaluated, the paper has to be completed and submitted in order to receive the full 8 credits (ECTS) associated with the course. The advantage of this part of the summer school is that participants start the course very well prepared.

Box 2: Examples of Summer School Themes (1991-2000)

1991 Valencia: **Healthy Lifestyle**

1992 Goteborg: **Promoting the Health of Children and Youth**

1993 Valencia: **Settings for Health Promotion**

1994 Liverpool: **Strategies for Health in Europe**

1995 Prague: **Networks and Collaboration for Health**

1996 Prague: **Innovation in Education and Training for the New Public Health**

1997 Cagliari: **Health Promotion and Research**

1998 Wageningen: **Participatory Methods in Health Promotion**

1999 Liverpool: **Health and Health Care**

2000 Zagreb: **Back to the Future**

Collaborative learning in the Summer School

A key strength of the ETC summer school approach is the social and cultural diversity of the participants and the interaction and exchange of cultural experiences throughout the summer school.

The ETC summer school is accredited and recognised as a European Master's level programme for professionals with an interest in health promotion and public health. It therefore attracts participants from a diverse range of backgrounds including public health, health promotion, health care, education, social work research, health management and health policy. The number of participants is limited to 30. Most of the participants come from European countries but the last 5 years we have also attracted participants from countries outside the EU, such as Canada, USA and Eastern European countries.

An important vehicle for sharing the social and cultural context of the different countries represented by participants is the preparation of a 'country profile' as part of the distance learning component. This can be an individual piece of work but where there is more than one participant from a country or region we invite them to produce a collaborative presentation, working mostly via email, or in earlier years, students would work together on their profile during the initial days of the programme. The country profile presentation, held in the morning programme during week one, typically includes some, but not only, population health data to illustrate the public health situation in participant's countries. Over time we (ETC) have focused less on this 'hard data' and discovered the benefits of focusing more on exchanging information about the different social and cultural 'nuances' in the various countries. We also encourage participants to include examples of national health promotion policy or practice. Some students use a comparative perspective to illustrate the differences e.g. between Northern and Southern European countries; others emphasise particular social or cultural aspects that influence population health or well being in that country for example social determinants of health, extent of poverty and inequalities in society, cultural migration, or the specific characteristics of the political party in power and how this affects health policy and practice.

The principle aim of the group project work is for participants, representing the diverse mix of social and cultural backgrounds and countries, to work together in a problem-solving situation. This encourages students to apply and appreciate the skills required to work according to the principles and strategies from the field of Health Promotion and from the student's involvement in the summer school. Most participants have many years of working experience and as such the group is an important resource in itself. On average the group size for the projects is six students per group. Each group has its own tutor who monitors the group work process and provides appropriate direction and support. The purpose of the collaborative project is to result in a research proposal, combined with an action plan, relating to the topic of the summer course; this is something that can be applied in the real world.

In particular we are looking for good examples of interdisciplinary working and an intersectoral approach to current issues in health promotion. Examples of the nature of projects are outlined below and in Table 1:

- a collaborative research proposal for European or national funding on a topic related to the course:
- Health in all policies;
- a research and / or action plan to initiate and sustain community participation (CP) and intersectoral work (IW);
- a plan to develop instruments to measure the effectiveness of community participation and intersectoral work;
- a proposal to operationalize and measure empowerment;
- etc.

Table 1: Examples of Project Titles including Aims (Years 2003, 2006)

Title	Year	Project Aim
We got the power	2003	To empower youngsters (11-14 years of age) to resist tobacco smoking
Health Promotion in an ageing European Society	2003	To improve quality of life for older people over the age of 65, in different settings within participating European countries
Empowerment as a process in reducing the number of young female smokers	2003	To increase the empowerment of young female smokers (aged 13-15 years) through the use of focus groups using "smoking cessation" as an indicator
Drive – thrive – stay alive	2003	To reduce deaths and serious injuries of young people between ages 17-25 in road traffic accidents (RTA's) in seven European countries 2004-2009
Constructing a children's and youth's resilience scale to be used in Europe – The challenges you are facing in a multicultural group	2003	To construct and validate a resilience scale for children and youth to be used in the European context
Bridging the Gap: increase equity and provide equal opportunities for migrants in 7 European cities	2003	Improving the health of migrants by providing equal opportunities in comparison with native inhabitants

Team members are required to work together to actively participate in defining the 'problem', write a team proposal including methods for data collection, formulate data analysis and synthesise conclusions and recommendations in order to come to consensus and understanding about what the project entails. At the end of the two

weeks the groups prepare a final presentation of the project outcome for the group as a whole. These final presentations include a poster as well an oral presentation. The experience shows that these presentations are very creative and that they symbolise a good process despite language, interdisciplinary or cultural differences that most groups experience.

Title	Year	Project Aim
H.A.P.P.Y. Healthy adolescents participating in planning of physical activity by youths	2006	To increase physical activity by 5% (number of children physically active at least one hour a day, some or all days of the week) at the end of the 9 months to improve lifelong healthy habits of Croatian school children aged 12
YIPIE Youth initiative for parent information and education	2006	To engage youth in developing and international health promotion internet tool to communicate their "life situations" with parents
The next generation; the future in their hands!	2006	To enable more school-aged children to develop healthy relationships and enhance health and wellbeing
Scenarios from Europe	2006	To decrease the number of unplanned pregnancies and STIs including HIV among young people in Europe
HUPC – Healthy Urban Planning for Children	2006	To create a community action framework to facilitate children's participation in creating a healthier neighbourhood; To create a healthier living environment in six communities in five European countries by a community participative approach to include the children's perspective in urban planning

Learning is both formal and informal but above all cooperative and collaborative in nature. This secures a learning environment that is conducive to trust and cooperation. Although participants must have a good level of English language to take part in the programme inevitably some students have better command of English language than others. This however is not a problem. Tutors create a supportive learning environment in which students feel safe to share experiences and explore innovative ideas but also over time participants develop a mutual respect fro each other and support each other in articulating these, regardless of the level of their English. Over time we have observed that this mirrors the inherently difficult process of multi-agency or interagency working for health promotion. Members of the group share the same goal but all bring different skills, sometimes language (professional jargon) and perspectives to the meeting table. As health promotion specialists when approaching a particular issue or task we sometimes forget what it is like to start a fresh or step back from the

discipline –to experience the 'anthropological strangeness' or a phenomenological 'bracketing of *prior* knowledge and assumptions'. This experience of the summer school provides each participant with a unique opportunity to view a task from a fresh perspective. This experience is very powerful for participants. They have to slow down, reflect, articulate and marshal their arguments carefully and robustly in order that they effectively engage the support of the group. It is not sufficient to deliver a task at the end of the programme that is only applicable to one social and cultural society or context. It must be developed by and for the different countries reflected by the participants in the Group. It is this concept that is unique and fundamental to the success of the group work project adopted by the ETC summer school.

Role of tutors

Instructors are seen as designers of learning environments that improve on the quality of student learning rather than deliverers of content knowledge (Hernandez, 2002). The tutor's role in the Summer school is one of facilitator and moderator. Tutors are not there to lead the process or provide a definitive answer. They act as *'sign posts'* and steer the process in a productive direction. Initially they contribute to identifying learning objectives and formulating problem statements – and ensure the chosen learning objectives are realistic. They ask questions that stimulate students to work on a problem in greater depth. Further, the tutor gives advice on how to collect information. And last, but not least, contribute to solving group conflict.

The ETC tutors are a small group of 6-10 tutors, depending on the numbers participating in the Summer school. Many have been involved in ETC since the outset in 1991, either as a participant themselves or as a tutor. New tutors are recruited over the years from participants who have attended the summer school and are therefore familiar with the values and concepts. New tutors who want to join the consortium first have to take part as a student to learn about the teaching and learning methods. The next year they work together with a member who already has some years of experience.

The tutors enjoy working together and are a strong and supportive team; they are not paid to participate in the programme and most use their vacation time from

Concha Colomer, Maria Koelen, Paolo Conto, Cagliari, 2003

their full time employment. They are all highly experienced academics or professionals with experience of teaching who attend during the whole two weeks. All members of the Consortium – the tutors- are involved in European health promotion projects. As such they are involved in the process of group development and they are present during the discussions and morning lectures.

Within the Group Work element of the summer school tutors have a particularly important role in coaching and facilitating learning. Here they act as facilitators by trying to clarify questions of the group and by helping out were necessary. They make sure the group feels ownership of the project and the challenge they want to deal with, that everybody is involved and that culture and language barriers can be overcome. They also try to facilitate that all knowledge available in the group is being used towards a situation, which creates synergy: a group of people with different talents and backgrounds can reach more than a single individual.

Group conflict is a common occurrence in the group work element of the summer school but as the pedagogic literature suggests conflict is widely acknowledged as a normal and inherent part of the process for effective group work. The ability to manage conflict requires a mutual understanding and respect of the different contributions of a group and of a multiagency collaboration (REF). This is practised and mirrored in the ETC summer school. Students therefore reflect on the process experienced and value the opportunity to visualise and experience this in practice.

6th ETC-Course Prague, 1996

Student's responsibility

Students are expected to take an active role especially during the project group work. The take responsibility to move through the stages of the process; reflection upon and challenging principle ideas and concepts as the emerge in the group process

Common responsibilities

Tutors and students are responsible for the group functioning well, socially and academically. It is important that feedback is timely and constructive; evaluation and reflection and feedback should flow in both directions, both from the tutor to the students and from the students to the tutor. The group agrees at the outset some mutual expectations and ground rules. At the start of each subsequent session the group reflects upon the group process.

Summary and conclusion

In conclusion, the key design elements of the ETC summer school are fairly simple but effective. Unlike traditional programmes of study whereby the emphasis on delivering or 'transmitting' detailed technical information to passive participants, this model is active adult learning style based upon the principles of cooperative learning. Unique to the ETC programme is the fusion of professionals, with exchange of rich and current ideas on Health Promotion theory and practice, in a safe environment. The deeper learning occurs through the process of exploring, listening and engaging in dialogue with professionals (participants and tutors) from broad and diverse social and cultural backgrounds. Moreover, the 2-week process itself offers participants insight and skills in being able to work across many different languages and cultures, to master the real demands of working collaboratively in multi-disciplinary subject (Health Promotion) and multi-agency approach.

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From Knowledge and Facts to Reflections – the Turn to Competence Orientation in Distance Learning

Arnd Hofmeister

Abstract

In this paper I analyse the changes of the format of the distance learning part of our summer-courses since its introduction in 2002. These changes reflect the development of distance learning in the last decade: high expectations and disappointments about the possibilities of information and communication technologies especially for the internationalisation of study programmes; the successes of capacity building in health promotion; shifts from a knowledge focus to personal reflections in higher education. This development mirrors and substantiates the changes in pedagogical concepts in higher education and its turn from a focus on knowledge and curriculum development to a competence orientation.

1. Background: Why we started with distance learning,

The first 10 years the ETC summer courses in public health and health promotion lasted three weeks. In these three weeks participants were on the one hand listening to lectures in the morning and working on individual projects in the afternoon. To imagine such a long period in the summer for a postgraduate training today sounds challenging. Only a few people would invest three weeks for such a course. Also for academics the tighter schedule in universities would not allow such a long period for an international training course. Training and qualification had to become more time efficient (Umble et.al. 2003). Comparable summer schools in public health today often last only one week. These changes indicate the growing speed of life and the intensification of educational and learning processes in the 21st century. That has a lot to do with the technological revolution around information and communication technologies (see below). But the evaluation of the summer courses in the end of the millennium made clear, that three weeks were too long and working on individual projects did not seem to be adequate anymore. This does not mean that the programme until then was not successful and appreciated but taking the evaluation seriously – one of the definitive strengths of the ETC-Consortium – changes were necessary.

So with the turn of the century there was the decision to reduce the duration of the course in the summer to two weeks and to replace the third week by a distance learning period before the actual summer course. Again this was possible for such an international group mostly because of the technological revolution. International communication, cooperation and co-production were made so much easier and quicker. So not only allowed the distance learning period students to prepare for

the summer course with the aim to create a similar knowledge base for all students, but during that phase students were supposed to develop competences in online communication and cooperation with other participants with whom they had to collaborate later on. Such competences have become since then central qualifications in all professions (European Commission 2010).

These changes in the structure of the summer school had also a lot to do with the changes in the availability of health promotion knowledge. When the summer school was introduced health promotion was still a new approach and literature was not available everywhere. Therefore lectures about the basic concepts and strategies of health promotion were still an important way to build capacity. Three weeks with lectures and project work were necessary. With the turn towards the knowledge society (Heidenreich 2002), the digitalisation of knowledge, and the development of the Internet the availability of literature and information increased. Especially for an international learning project with participants from all over the world the distribution of information and literature via the Internet was a necessary precondition for the introduction of the distance learning part. The participants were organised in distance learning groups, tutored via the Internet, and essential readings could be provided online.

To conclude, the introduction of the distance learning part is a reaction of the ETC group towards the changes of the conditions of international learning experiences regarding the increasing speed of learning as well as the development of information and communication technologies.

Methodologically this paper is a theoretically inspired experience based analysis of 10 years of distance learning in the context of the ETC summer schools in Public Health and Health Promotion. The empirical basis are on the one hand the written distance learning tasks from 2002 to 2011, the evaluation of the distance learning part by the students during and after the summer schools, and finally the evaluation of the distance learning part by the tutors. We developed two kinds of evaluation: one was the quality of the distance learning essays itself and the other one were group discussions during the preparatory meetings for the next summer schools. At these meetings we reflected the relevance of the distance learning part for the last summer school.

2. The development of the DL-Task

The distance learning element is from its beginnings until today divided into two major sections. The first section entails an individual task, which comprises basic readings and reflections about health promotion and the specific topic of the respective summer school. It has to be completed by a written essay, which has to be handed in before the actual summer school. The second section includes the preparation of the so-called “country-profile”. This is a presentation of the country during the summer school the respective participant is coming from. It is a joined presentation of all participants from the same country. The way we formulate these two sections

changed continuously in the last ten years. In this part I will describe and slightly interpret these changes based on our experiences and the evaluation of the students; the second level interpretation follows in chapter four.

Looking at the first descriptions of the distance learning element, it is evident that there was still a focus on knowledge about health promotion. The general learning aims and objectives included knowledge about the historical development of, and current practice in health promotion and its critical appraisal, the student's home country's health promotion policy and the health profile of the student's own country. Furthermore there were specific learning aims regarding the respective topic of the summer school (e.g. mental health, globalisation, social determinants etc.). The compulsory readings included the foundational documents of health promotion and basic literature. The basic aim of this distance learning period was to create a similar knowledge base for all students before the actual start of the summer school.

The results of the essays and presentations were similar. Students reproduced the history of health promotion summarising the main results of the WHO health promotion conferences usually starting with the Alma Ata Conference on primary care. Especially with non-native English speakers we had to check for copy and paste contents from the websites of WHO and of the provided literature but generally we had excellent papers, which were more or less similar. Also the country presentations resembled each other. Power point presentations dominated the scene and we learned all about mortality and morbidity rates as well as physicians per capita ratios from the respective countries. In these first years the students and the summer school team were mostly fascinated by the immense availability of knowledge in the internet, so we appreciated the essays and the presentations, but we also recognised, that the way in which the essays were written and the presentations were given not really corresponded to our intention of a health promoting learning experience. Problem based learning was seen as the approach and the reproduction of knowledge fit not really to it (Boud, Feletti 1997).

To improve the distance learning element we added additional tasks in which students had to reflect their own experiences with health promotion and discuss their home countries health promotion policies in the light of the European Integration process. For the country profiles we asked students not to focus on public health figures and facts but more on their home countries culture and specific health promotion projects, which related to the main topic of the summer school.

The form of the country presentations changed a lot and became a highlight of the summer schools. Each presentation, whether done by an individual or by a group, was different: from animated power point presentations, to culinary specialities, to songs, and dances. There was a definite change towards more interactivity with the group. Participants started to productively "compete" with more innovations in their presentations. However, the written essays not really changed that much. Since the essays always started with the reproduction of the history and development of health promotion, the personal and political reflections remained in that frame and style. Our basic assumption was still that the distance learning element should provide a

similar knowledge base in health promotion in preparation of the summer school and therefore we thought we had to ask students to reproduce that knowledge. But in our evaluation discussions we started to doubt these assumptions. To give you an example: As an online tutor I received an email exchange between two students by chance (one of those emails everybody is scared to send unintentionally), were one student was commenting the task, announcing that she would copy paste one of her "boring 1st semester MA-essays". In our discussion of the essays, the evaluation, and after such comments we decided that we should take a different approach.

So it required major changes in the formulation of the distance learning tasks. We changed from a more deductive approach to a more inductive one. We thought that participants who decided for a summer school in health promotion already had some fundamental knowledge or would acquire this knowledge while working "problem based" on a specific topic. We formulated a rather broad learning aim without too many specific objectives. Then we asked students to start with personal experiences and reflections about the specific topic of the summer school - whether "Salutogenesis", "civil society", or "life course" - and their personal connection to health promotion. Only in a second step we wanted students to analyse their home country's health promotion policies and strategies. For the country profile presentation we now explicitly asked them to be innovative and try to give a flavour of their home country's culture and health challenge.

This major shift made a difference regarding the results of the essays as well as the country presentations. While in former years students were satisfied with a general feed back to their essays, the discussion of the experiences and "results" of the essays have now become an integral part of the programme. Students not only like to write about their own experiences but also want to share them with others. Since the focus of these essays is more related to the topic of the summer school, their results are of major importance for the programme itself to broaden the knowledge about the respective topic, to involve students individually, and to provide a culturally divers perspective on it.

The description and first level interpretation of the changes in the way we formulate the distance learning element for the summer schools shows that it is increasingly important to involve participants personally and to get away from traditional learning tasks with a focus on the reproduction of knowledge. The paradox of the knowledge society is that knowledge in the sense of pure information is boring, because it is constantly available for almost everybody. To make knowledge interesting for and to participants you have to develop a "personal" connection to it. In the knowledge society and its information overkill people need more and more a reason why they should acquire knowledge or listen to its provision. A personal encounter or an experiential approach is therefore a good starting point. The preoccupation that students might not learn and know enough about health promotion before the summer school, if they not study it explicitly, proofed ungrounded. The inductive approach starting with personal experiences leads students without any direction quasi automatically to general concepts, content, and knowledge. The consequences for a general didactics will follow later.

3. Distance learning, the development of Information and communication technology, and the internationalisation of learning

As already outlined above the development of information and communication technologies had also a severe impact on the summer school. It was somehow a precondition for the introduction of a distance learning element but it also changed the way we looked at learning processes and its facilitation. I will now briefly outline the changes of knowledge development, its technological provision, and parallel to that the development of international learning experiences.

The incredible availability of scientific literature (for all those with "access" (Rifkin 2001)) is still challenging the way we teach and learn. We as tutors and lecturers studied under fundamentally different conditions. In the 1960s and 1970s the main sources of knowledge were books and lectures. These are the late years of the so-called "Gutenberg-Galaxies" (McLuhan1962). There was no alternative either to listen to lectures or to read books and journal articles. However, the number of scientific journals was still very limited and access was mostly difficult, photocopying was very expensive. International studying and learning experiences were rare and bound to elite or to conferences, which were also held less frequently. Students who went abroad still studied with a famous professor or at a famous institution.

In the 1980s and early 1990s this already changed. The number of journals developed with the number of conferences; the distribution of articles, if not available at the institution itself, was still bound to hard (photo-) copies send by mail. However, the production of knowledge increased exponentially, at the same time the "half-value period" of scientific literature diminished (Kölbel 2002; Heidenreich 2002). The acquisition of expert knowledge was less and less bound to a face-to-face interaction with an expert. The number of textbooks increased and at the same time the standardisation of knowledge progressed. Learning shifted more and more from the acquisition of positive knowledge to an orientation-knowledge, the competence to know where to find the relevant information. This requires a different way of learning. Problem-based learning and experiential learning gained more importance (Boud, Feletti 1997). International learning experiences during that period became more available (Kerr 1990), but international telecommunication was still an expensive challenge.

The ICT revolution challenged the whole way academic learning and teaching was organised (OECD 2001). We are still in the middle of fundamental transformations because those who are teaching at the moment learned under fundamentally different conditions and therefore often pity the loss of learning cultures of the so-called copy-and-paste-generation. The introduction of full text online databases and electronic versions of textbooks, in which everybody can easily access complete texts already in an electronic version, not to forget websites like Wikipedia, make everything ready to be integrated into the own current text production. While in former times summarising a textbook or a photocopied article required own writing skills and helped to paraphrase texts and to reconstruct the train of thought of authors, it is easier

nowadays to produce a patch work of already written texts. Knowledge is available online in differently grained states: from raw data, over executive summaries, to comprehensive studies. In a situation of growing complexity, where it becomes more and more difficult for students to integrate knowledge, "to put together the reality bites to a complete whole", copy and paste compositions without any argumentation are common results in higher education essays. While for us as tutors in health promotion who still studied with a meta-narrative of emancipation (Lyotard 1984), the integration of complex knowledge is easier; it remains difficult for students today. With the end of the hegemony of that narrative, new ways of integrating knowledge for younger generations have to be developed.

All those who studied before the ICT revolution have to reflect in their conceptualisation of learning and teaching processes three fundamental changes: there is no dominant meta-narrative to integrate knowledge, the endless availability of knowledge requires a different approach to learning, and finally learning processes require still some kind of personal relation. Looking back at the last decade of the development of e-learning these lessons have still to be learned.

When we developed the distance learning element we tried to use all new possibilities. We provided many readings as pdf-files hoping students would read them. We integrated our distance learning element in different virtual learning environments with forums and download areas and expected students would start communicating with each other before the actual summer school. We build e-learning tutorials hoping that an email discussion would start.

Looking at our experiences it became clear, that using professional learning environments was not successful (e.g. blackboard, moodle, web-ct). The evaluation showed two different results. Participants who were still students were usually enrolled in one learning environment at their university. An additional one was too much to handle especially if it is only for a small summer school. For them as well as for professionals it is an additional hurdle to learn how to use another learning environment with its broad variety of possibilities and features. At the moment we are working with a small-scale platform, which provides only those features students, need.

The online exchange of students before the summer school is still very limited. It only takes place where communication and discussions in the e-tutoring groups are facilitated. Looking at the evaluation we found three reasons. Firstly the participants are either fulltime students or practitioners who have to do the distance learning parallel to their job. So their timing differs. Discussions online are only productive, if students work at the same time on similar questions. An answer to a comment after 2 weeks is usually not relevant anymore. Secondly students respond more likely to comments and questions from people they personally know. E-learning also requires somehow a personal relationship either among learners and/or tutors. Finally we all have to manage a lot of communication, so nobody is looking for more unless it is necessary. This is reversely proofed by the fact that the communication among participants increases after the summer school as friends and as professionals.

Looking at our experiences with the ICT revolution and comparing it with the general expectations for the internationalisation of learning and studying the conclusions might seem disappointing. Although the possibilities for a virtual international exchange increased, they are not used in the expected way. The possibility of international exchange does not motivate students automatically to start communication. If there is no definite facilitation, exchange processes do not start only because there are facilities. The increasing availability of knowledge does not improve the quality of academic work. There are so many texts about any academic topic, that the pure provision of these texts is not helpful anymore. Clear comments why students should read a text and what is significant about it are necessary. The quality of e-learning and distance learning is not constituted by the quantity of material provided but the quality of its organisation. Finally to be successful e-learning requires intensive tutoring. There is no automation in learning.

4. From knowledge and facts to competences and reflections

In this part I will reflect the development of the distance learning part of the summer school programmes in the light of major changes in the discourses on higher education in the European Union. These changes are characterised on the one hand by the Lisbon Strategy, which aims at the development of knowledge based societies focusing on IC-Technologies and on the other hand by the Bologna Process which aims at creating one European space for higher education.

Looking at key words for European research and development projects in higher education in the last decade following the Lisbon Strategy in 2000 there was no way to be successful without an extensive use of ICT and of promises about shared e-module development. Nowadays web 2.0 technologies, second life or similar technological developments dominate the discourse. Self-directed learning or problem-based learning is regarded as the pedagogical approach. The reality is often more down to earth and disappointing. ICT technologies are only used for the provision and exchange of information but less for learning and co-production. Shared e-learning processes are only successful were they are strict time rules and very structured learning environments. Problem based cooperative learning processes are rather difficult in such contexts.

With the Bologna Process in the late 1990s a second trend in the EU began which first focused on curriculum development. The idea of shared study programmes, common degrees and commonly used modules was dominant. These developments are still on going but are complemented by programmes on competence development. In health promotion and public health it started in 1998 with the “European Master in Health Promotion (EUMAHP)” Project in which a shared core curriculum was developed and disseminated. Parallel projects in Public Health Nutrition and Public Health Gerontology developed. All three were supposed to bring together their experiences in the “Public Health Training in the Context of an Enlarging Europe (PHETICE)” project. The development of a common core curriculum helped to establish Master Programmes in Health Promotion in several EU countries, but due to the

different forms and degrees of professionalization of health promotion curricula still differ a lot. The trend changed. It is now less the content or the study programmes, which are commonly developed, but rather the core competencies, which should be, acquired at different qualification levels in health promotion. Knowledge plays a minor role. It is more the application of knowledge, its critical judgement, communication competences, and learning competences, which are in the centre of attention (see Dublin Descriptors). Current projects like CompHP are working in that direction.

This turn to a competence orientation in e-learning as well as in curriculum development is characteristic for learning processes after the ICT revolution. In the light of these changes our experiences with the distance learning part of our summer schools are important for the future development in health promotion training. To make health promotion training a health promoting experience it is not sufficient to provide knowledge about the history of health promotion even if it is told as an emancipatory story in regard to our understanding of health. The acquisition of knowledge should be an integral part of practical activities, which connect the information pieces to a coherent whole, which is understandable and meaningful. This is usually realised in a problem based learning process with a lot of interaction with fellow students. In distance learning this is more difficult. IC-platforms are useful for the provision of information. The organisation of communication processes not to talk about co-production processes requires a lot of organisation and commitment. Since the learning relation in such a summer course like in most distance learning programmes is for the time of the distance learning part rather ephemeral our solution to this challenge is the personalised approach. We are asking students to connect with the knowledge and practice of health promotion via their personal experiences and reflect them with a focus on the specific topic of our summer school. This strategy prepares them in a health promoting way for the summer school. Instead of focusing on the knowledge

12th ETC-Course 2003, first in cooperqation with EUMAHP, Cagliari, Italy

development we focus on the development of personal and social competences. Students build a personal connection to health promotion theory and practice. The discussion about these experiences during the summer school with fellow students integrates this personal approach in a social context. The other learning experiences during the two weeks in the summer (see Pavelcovic in this volume) add the rest and make this learning process a coherent health promoting learning experience. It is the integration of personal, social, and methodological competences with knowledge that are important and allow students a comprehensive approach to health promotion theory and practice. Distance learning alone could never provide the possibility to acquire these competences; only in a blended learning format it develops its strength. The mayor challenge of health promotion training is the integration of these different elements. ICT is a tool for learning and cannot replace social interaction and personal contact. The knowledge society requires more personalised contact and not less, like fantasies of automation of learning by computer programmes might suggest. They might work for exercises to test knowledge but not for comprehensive learning processes.

Tutors Meeting, Zagreb, 2006

5. Conclusion

Our experience with distance learning is quite counterintuitive. Although or because the ICT revolution allows endless access to knowledge, we have to ignore the temptation of overkill with information. We should rather create opportunities for students to connect with knowledge and to find their own pathways, which we accompany. If our aim is the training of critical thinkers who learn about health promotion in a health promoting way the art and science of health promotion pedagogy has to shift the focus from knowledge to competence. Here personal, social and methodological competences should be integrated in learning opportunities. This requires a blended learning format. The distance learning as a preparation should open the students for such integration processes and to let them and their experiences be part of that, but direct interaction is the prerequisite for health promotion learning. The narrative of empowerment which we tell each other in our summer schools and which helps to integrate the knowledge and practices of health promotion follows a bottom up approach. We start with our personal experiences and integrate them in a second step in a social and in a third step in an organisational and political context. At least until

now we are very successful with this strategy, but we are always open for changes, as health promotion also is more a process than an outcome.

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Evaluation

Gordana Pavleković, Klaus Pluemer

There is no doubt: the short-term courses or training programmes with the key word „health promotion“ are present today on the European and world market. If you want to invest, at least, a financial (often personal) input as well as your time (usually summer holidays), you are faced with questions on evidence-based effectiveness and efficacy of those programmes for your professional development and personal expectations. Therefore, evaluation of any training programme, including the ETC-PHHP course, is the key element for marketing the programme.

Traditional issues in evaluation are based on certain questions, like:

- Why should evaluation be done?
- What should be evaluated?
- How to do evaluation?
- Who is involved in evaluation?
- When to start evaluation?
- Responsibility for evaluation?
- To whom is it addressed?

On the other hand, evaluation in Health Promotion means „Not to prove, but to improve!“ or in short, „knowing whether a programme succeeds or fails is important; it is important to know why a programme succeeds or fails, but what is happening is much more important“. It means that evaluation of the ETC-PHHP summer course is more complex when compared to other similar (national) programmes.

Over the past twenty years of running this programme, we have used different methods in assessing the quality of the ETC courses. Some referred to internal evaluation made by course participants, others to external evaluation and, probably the most important, those made by organizers, tutors and lecturers.

Internal evaluation: Assessment by participants

This evaluation is mainly based on **process evaluation** with the aim to improve the quality of a training programme and to balance between expectations and final outcomes. Two methods have been used: individual (anonymous) questionnaire after the first week of the programme, and final evaluation based on individual letters addressed to tutors.

Example of assessment by participants after the first week of the 2006 ETC course in Zagreb.

	Positive	Negative
Distance learning part	Enough time Relevant to the Course Interesting references Useful, good preparation in advance Positive feedback from my tutor made me proud Fast and extensive feedback Good review of the HP history Consciousness of my country perspective	Hard work
Settings	Very good organization Quiet and academic, excellent and amazing, organized team to present the setting High level of standard (facilities, rooms) Supportive environment in which to learn and staying together in the same place means we got to know each other better	No air-conditioning (bedrooms, restaurant) Everybody should have stayed together Food/coffee breaks more fruits! One elevator for many people Lack of paper
Programme	Well organized Comprehensive Intensive and high level of professionalism of lecturers, tutors and participants Different lecturers and different perspectives Good balance between morning and afternoon sessions (theory and practice) Country profile presentations The teachers' enthusiasm for HP	Too much lecturing and not enough interaction Some presenters made a long presentation with too many details and slides and no clear idea Too basic issues Max 45 minutes for lecture 15 min break Longer country profiles - more in-depth info to enhance European dimension Country profiles during the whole Course More European dimension (successful examples) Theoretical background for the project development should be stronger Little bit too busy for leisure time
Personal feelings	Happy! Sense of belonging Enjoying the others, specially tutorial group New way of thinking Very good! Learning a lot Improved my English (starting to understand English better)	Tired! Teachers are not with us during the breaks A challenge to do a group work (leaving a group) Sometimes I wanted to say more than my ability to speak allowed!

Citations from the Letters addressed to tutors

"It is the first experience of this kind; it is not only "I" has a problem, it is "we" have a problem… It is not only listening to the others, accepting ideas…. It is also a feeling that you are not alone… learning how to receive ideas from others, how to accept them, how to adapt them…. It is important to learn a new way of thinking…. to make the change from negative view on health (illness, mortality) to a positive view, endorsing the spirit of HFA."
(Participant, 1992 ETC-PHHP Summer Course)

„I am leaving with something to take back home"
(Participant, 1997 ETC-PHHP Summer Course)

"I have learnt a lot: maybe not so much about formal topics, but most about cultural differences and how difficult and challenging the struggle for a common understanding its. Frustrating and interesting!"
(Participant, 1995 ETC-PHHP Summer Course)

"I loved learning about everyone's country through the country profile presentations. What was even more interesting to me was to see the creativity, energy and different approaches that each group took to this task… It was inspiring to think beyond the PowerPoint presentation-of-facts box. It made me reconsiders the creativity I bring to my own work and appreciate more an arts-informed approach to health promotion."
(Participant, 2008 ETC-PHHP Summer Course)

"These two weeks has passed so fast. We have been busy and I haven't had any problems with getting to sleep in the evenings. When thinking the timetable backwards it has been busy but very interesting."
(Student, 2006 ETC-PHHP Summer Course)

"We worked a lot, we learned a lot and we lived a lot: a great experience!"
(Participant, 2009 ETC-PHHP Summer Course)

External evaluation: ASPHER PEER review

At the beginning of the 1990s, ASPHER (Association of Schools of Public Health in the European Region) in collaboration with the WHO/EURO (World Health Organization, Office for Europe) stressed the need for knowledge-based response to the new and emerging European challenges in public health. ASPHER had created a quality development process based on a review by peers (Public Health Education European Review, PEER). The ETC team members invited the ASHER team to review and accredit the ETC summer course as an example of a training programme which would be widely recognized as training with a European perspective.

The visit by the ASPHER peer review team, professor Franco Cavalla, University of Torino, Italy, and professor Jacques A. Burry, at the time the executive director of ASPHER, took place in August 1997, during the ETC-PHHP summer course in Cagliari. Professor Evelyne de Leeuw from the University of Maastricht, the Netherlands, participated in reviewing the ETC self-evaluation documents.

In their final PEER report, they wrote:

„...The ETC summer course is not just another international course with a few faculties and a few students coming from different countries. It is a valuable product or learning offering. It has a specific profile of the only really European training course. In this respect, it is a total success....“

„...It is a course planned and delivered by a group of trainers and a group of students, coming from many different countries, without any „dominating“ the scene, and focusing on European health promotion policy and strategy with a reasonably student centred approach. In that respect, it is not only a success but a model...“

Instead of a conclusion

It is not simple to assess/evaluate this ETC programme based on „healthy learning“ and/or impact of the European dimension on health improvement. It is recognized that, not only for this particular training programme but also for all others, it is important to develop special evaluation tools as well as measurement instruments.

Based on the twenty years of the ETC-PHHP training programme experience, honestly and in summary, this programme has the following strengths and weaknesses:

Strengths	Weaknesses
Agreement 2000-2005 Agreement 2006-2010 Agreement 2011-2016	Light organizational structure: agreement does not include formal obligations, particularly concerning finances
Course fee payment by participants: highly motivated persons	Lack of stable funds, disturbance in the number of participants
Close collaboration of a core group of representatives of partner institutions with high synergy and efficacy	Consortium as a personal ownership more than a partnership between
European added value: networking	Lack of evidence-based of long-term effect: how learners continue to work and change perspective in work at home and in co-operation with others?

“When experienced people have a chance to spend three weeks together in rethinking about what they are doing every day and in listening to colleagues and friends from all over Europe - then - they are learning. They learn to understand their own strenghts and weaknesses, they learn the importance of careful listening, they learn the importance of not making assumptions. They start to appreciate the value of their own experiences and learn what it means to be self-confident and self-reliant. They recognise the role of a leader, a master, a fighter and a humble human being for the demanding goals in reaching Health for All.”

(Jannika Larssen Lundgren, participants, ETC-PHHP Course, 2000)

Part 2
Reflections on the Last 20 Years by Founders

Verba Volant, Scripta Manent: Random Reflections on 20 years' Pan-European Public Health Collaboration

John Ashton

Where to begin on a journey with many entry points, both geographical and personal? Perhaps one day in Liverpool in the mid-1980s, when Paco Bolumar turned up from Alicante out of the blue, accompanied me round the supermarket to do my family shopping, and disappeared like an enigma, leaving behind an invitation to meet and work with Concha Colomer and Carlos Alvarez to resurrect the teaching of public health in Spain in the new post-Franco era.

Perhaps on another day, in the summer of 1985, on the way back from a family holiday in Sweden where we had been visiting Bo Pettersson and friends from the Swedish Board of Health, when the decision to find out who this woman Ilona Kickbusch was who had begun to make waves in the new world of Health Promotion led to an invitation to coordinate the new WHO Healthy Cities Project, drawing on the work of Howard Seymour and myself in putting the New Public Health into action to tackle the interacting issues of sexual health and the new scourge of HIV/AIDS.

Or perhaps, again in Copenhagen, on a very snowy day in February 1986 when a strange assortment of characters from different countries and disciplines sat down around a table to plan what Healthy Cities was to become. At a certain point Len Duhl, practising Psychiatrist and Professor of Public Health and Town Planning at Berkeley University in California, pointed out that each member of this diverse group seemed at some point to have changed disciplines - an observation that might bode well for a project seeking for inclusive and holistic thinking about the urban condition.

Whatever starting point we take, it has been a remarkable venture. In retrospect I can see that, as a group and a formidable network, we have instinctively stayed true to the principles of Health for All and much more besides. Ilona launched a thousand ships from inside a horrendous bureaucracy, whilst at the same time setting up a project which always struggled to escape the tentacles of top-down control. Perhaps it was inevitable. The relationship between those early Healthy City pioneers was an important one, and the cross-fertilisation can be felt over more than two decades.

The WHO's desire to develop a European Masters course in Public Health, built around the 38 European targets of Health for All by the year 2000, may not have been realised, but our piece of it – the Health Promotion piece – has defied politics, geography, personality and resource to be an enduring manifestation of a spirit which was so exciting in the 1980s. Without realising it, we were working to John McKnight's script of Asset Based Community Development: mobilising the energy and passion of hundreds of people, using what we could find in our own backyards to keep the show on the road. A handful of dollars went a very long way!

At the Healthy Cities conference in Zagreb in 1988 our Croatian friends, with the leadership of Slobodan Laing, provided the very paradigm of how to do Public Health. With the Balkans spinning out of control, rampant inflation and starving Zagrebians going into the woods in search of mushrooms to stave off hunger, the city was to host a WHO international Healthy City meeting with a budget of $1000.

The challenge was duly met. A luxury hotel [name please, Goga] was persuaded that, in the interests of civic pride, it should make its facilities freely available for the conference dinner. Food distributors were persuaded that it was their civic responsibility to feed several hundred international delegates. And the country's leading musicians and artists were persuaded that it was their responsibility to perform free of charge, or donate works of art to be auctioned to provide television sets for children with learning disabilities living still in institutions. When delegates came to the conference dinner there was a special guest at each table: a long-stay psychiatric patient. Reciprocity was built into the conference, and each delegate was charged with carrying out a community task, such as going into a school and talking to the children about life in another city, in another country.

15th ETC Course, 4th in cooperation with EUMAHP, Zagreb 2006

Slobodan Laing argued that luxury hotels were normally very expensive, so for a day at least this one in Zagreb was free. In the same vein, he argued that normally it was free to go into a cathedral, so, for the conference concert provided by the same

artists, payment would be required of delegates to buy more television sets. And at that same event, the Communist mayor of Zagreb and the Roman Catholic bishop were under the same roof for the first time in 50 years.

The final day, International Solidarity Day, saw the concerned solidarity walk with paraplegic patients along the river to a park where a barbecue had been prepared by the Red Cross – the condition being that delegates were expected to donate blood for the local health system! Such were the inspirations that fed into the development of the ETC summer public health training schools taking turns around Europe from Goteborg to Sardinia, from Liverpool to Prague and from Wageningen to Valencia. A bonus for many of us in Prague was our summer school coinciding with a Rolling Stones concert in the city stadium. (The full list of summer schools is to be found as an appendix.)

In 1990 at the Healthy Cities conference in Stockholm, and genocide on the horizon, Slobodan suggested to me that it was time to define hatred as a public health issue. The resolution, quoting Helen Keller, was the result and was adopted by the meeting [resolution to go in here as a figure]. This statement was subsequently presented by a Lithuanian member of parliament from Kaunas to his parliament at a particularly dangerous moment in the separation of the Baltic States from the former Soviet Union. We had a glimpse of the power of Public Health thinking to influence the human condition on a larger canvass. Not for nothing has Public Health been described as the political wing of medicine (or population health).

People, places, personalities, times, opportunities – we have lived through a very eventful time, when Public Health thinking was never more needed. I would like to think that our consortium, with its hard core of devoted facilitators (you know who you are!), has spread the word, handed on the baton and built capacity across Europe in a way that many, much better-resourced programmes have failed to do. We have seen young professionals come through our summer schools and go on to leadership roles in their own countries, and in turn develop extensive networks and systems to build yet more capacity.

Like rings on the water, those first stones continue to ripple out. On our twentieth birthday, let us recommit ourselves to this work and be even more ambitious for the next twenty years.

The History of the ETC Beginnings

Selma Šogorić

Maybe, you are curious to find out where did the idea for the development of our ETC came out. Hence, starting from the principles agreed in the year 1978 at the International Conference in Alma Ata and because of the difficulties in the realisation of the strategy „Health for All by the Year 2000“ The World Health Organisation, on its regular General Meeting in April 1984 decided that it required a greater engagement of University and High School institutions from around the world. In this way, through academic and educational authorities WHO could find paths to achieve the agreed strategy of “Health for All”.

The School of Public Health „Andrija Štampar“ at the University of Zagreb School of Medicine, already affirmed in its long tradition of connecting („bridging“) the public health necessities with the science and possessing the responsibility of the World Health Organisation collaborative Centre for primary health care, had a lot of comprehension for this demand. The first of its activities aiming towards this direction which started already in June 1984 was the foundation of the School: Health for All as a part of the Inter-University Centre for Postgraduate Studies in Dubrovnik. In collaboration with other European and world Universities, through the courses of the School: Health for All started the education for the implementation of a wide range of ideas agreed upon in Alma Ata. Topics ranging from the education of the educators in family medicine, development of health care system research, social gerontology, medical ethics and quality of life, health self-care and mutual care to Healthy Cities.

Inspired with our own refinement through the collaboration with other Universities we were eager to greet the incentive from the European office of the World Health Organisation referred to ASPHER (Association of School of Public Health in the European Region) in the year 1988. The aim was to develop a model of the so-called European Public Health Postgraduate Study through the consortium of public Health Schools. The majority of readers will not be surprised to hear that the suggestions on „how to perform it“ were the major discussion themes on the two working meetings of ASPHER (Rennes, France and Seged, Hungary), on the thematic workshop held with the representatives from EU WHO in Gothenburg, Sweden and a series of smaller operational meetings. Finally, in the year 1990 we reached a consensus – to constitute few thematic consortiums which will develop materials on lifestyle and health, environment and health, health care system and others. Our consortium which consisted of already well established partners from the Valencia School of Health, Liverpool Public Health Department, Nordic School of Health and Štampar School of Health accepted the theme „Lifestyle and Health“. It was not easy at all. It took us a few arduous working meetings to discover the educational formula, which, more or less successfully, we use till today; also attractive editorials, interesting practice work, case studies and students work on the project with mentors. So, we were ready to start. The first course was planned to start in the summer of 1991 in Zagreb. The

rest is known. The starting of the war in Croatia demonstrated that we have good partners. In only a few months time the hosting of the first course was successfully undertaken by the Valencia Health School, and so it started...

13th ETC-Course, 2nd in cooperartion with EUMAHP, Galway 2004

The Early Stages of the Development of the ETC Training Course and its Learning Model

Bengt Lindström

It all comes as a surprise to us TWENTY YEARS. It can´t be true. ETC has throughout its 20 years been a garden and laboratory for learning experiments and experiences. Having been part of each course since the start in 1991 I have seen the ETC core concepts develop and the practice change. At the starting point Heath promotion was a new topic that was still in its cradle and formation. Having been given the assignment to implement the Health for All by the Year 2000 Strategy regarding Lifestyles in health promotion in European training by WHO-Euro and ASPHER we had an enormous challenge. In spite of some preceding workshops there was no manual to follow. In practice we had to create everything on our own. I arrived to the first course with 64 kilos of books, overheads and documents, most of that never came to use in spite of paying for the overweight. Each of the four Institutions came from their own corner of Europe, representing different cultures also regarding traditions in education, some even more top down than the others. In relation to Public Health and Health Promotion Liverpool was a stronghold for the settings approach to health, Valencia again had a strong emphasis on health promotion focusing on policy and community intervention, Zagreb based its knowledge on Andrija Stampers' ten principles and primary health care and Göteborg again had a learning fundament in international interdisciplinary and intersectoral training and a strong focus on wellbeing and quality of life.

The Context 1991

The Global historical context at that time (also in Europe) was more than exciting. In the planning meeting in the early 1991ies when we still thought the course would run In Zagreb, *Yugoslavia* "the Desert Storm" was launched and the bombing of Bagdad initiated. At that time we did not know there would be a full war in the Balkans but as things escalated towards the summer we were forced to shift the site of the first course to Valencia. To mark history, Gorbachev was ousted and the Soviet Union collapsed the same day the course started in August. At least half of the participants came from the Eastern parts of Europe and there was a lot of worry and tension amongst them and the tutors because of this. However, this strengthened our focus on the role of Health as related to basic human rights and peace on earth, the prerequisites of the Health For All Strategy stated peace as a fundament for a healthy development.

The Course and first experiences

Going back to the course itself, each of the four institutions had allocated one teacher/ tutor for the course, Selma Segoric, Concha Colomer, Aislinn O´Dwyer and Bengt Lindström. Most of the formal "teaching" was allocated to external teachers, what we called "Super Stars", that is people who were on the frontline of Public Health and Health Promotion. This did not only mean the students met some of the most prominent experts but we all learned and drew our conclusions for the future. But the learning process was not only based on traditional teaching most experts were running interactive sessions. However, half of the course time was allocated to tutorials and student based projects and fieldwork. I remember some rather exhausted students having to push a wheel chair for hours from the centre of Valencia in a temperature above + 40 degrees centigrade because the public transportation system refused to take wheel chairs on board. The student based learning was to become the trademark of the ETC courses. In the first courses the examination/projects were individual but we soon changed the format into group work to enhance the learning from different countries and cultures. The Health For All strategy which is probably was the most important change in Public Health Policy in the 20th Century had launched some core concepts: Adding Years to Life (AYL) – the traditional prevention of disease and risks, Adding Life to Years (ALY) – the focus on wellbeing and Quality of Life, further including: sustainability, equity in health and intersectoral and interdisciplinary action. This was scrutinized by the students and processed together with the Principles of The Ottawa Charter of Health Promotion (determinants of health, empowerment, health as a process developing conditions towards wellbeing and quality of life. Already in the first course on of the future landmarks of the ETC was touched upon: to focus the outcome of the health process on wellbeing and quality of life and discussing the resource approach to health rather than focusing only on risks and disease. Based on the experience of the first course we reduced the number of external experts and soon the courses were run mainly on our own expertise where the external experts only were highlighting some specific themes using exclusive world experts, such as the father of Salutogenesis, Aaron Antonovsky having a full day session in the Second ETC course in Göteborg. He was on his way to introduce Salutogenesis in a health promotion workshop with WHO Euro in Copenhagen.

The Key to Success

It would be too long a story to try to link together 20 years of experience in a short presentation. Instead I can reflect on what made the ETC a success. The ETC has largely been a pioneering process in health promotion training. We had the strong support of our institution leaders and the trust we could do it. In spite of the very different traditions of the institutions they're quickly developed a deep trust, openness and friendship, which served as an emotional climate for good learning. Nobody was allowed to dominate one element was to change site each year. It was a democratic process, sometimes lengthy and hard to achieve, of course we had our internal conflicts and fights but nobody was allowed to dominate. ETC has also been able to maintain the

"ETC culture" – we have been able regenerate ETC being flexible and open minded, all tutors, except one, have changed over time and we have slowly increased the number of institutions involved. Each new one had to try out ETC in reality before becoming a member. The strong focus on students and to facilitate interdisciplinary learning between the European cultures and beyond has been important. The participants have paid their own way meaning they were motivated to come and ETC has never primarily run on external funding.

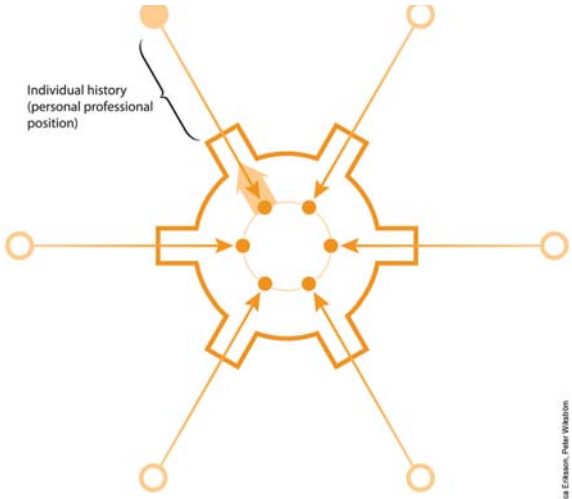
The Heritage and Scientific Basis of the ETC Learning Process

Having had this wonderful opportunity to see the ETC courses develop into what ETC is today I want to leave my mark on this book by focusing the rest of the text on how I have come to implement the learning principles of health promotion into a salutogenic learning process: Now myself being in charge of the IUHPE Global Working Group on Salutogenesis. Some of the credit for this is definitely stems from the experience of the ETC. Therefore I end this text with an extract from the Research Report "The Hitchhiker´s Guide to Salutogenesis. (Authors Lindstrom, B., Eriksson, M. published by Folkhälsan Research Center in Helsinki – see www.salutognesis.fi)

Extract from the Hitchhikers Guide to Salutogenesis

The health process can be seen as a learning process where we reflect on what will create health, what are the resources for health and the improvement of quality of life. As shown earlier in this book it is obvious the Ottawa Charter can be given a salutogenic interpretation (Eriksson and Lindström 2008). Both can be seen as lifelong learning processes. In health promotion the salutogenic learning process can again be seen as a healthy process that leads to the improvement of quality of life and wellbeing. Another aspect is the fact that one of the key processes of health promotion, empowerment is more of a principle that in fact lacks a theoretical foundation. Empowerment could gain from having a theoretical foundation in the Salutogenesis. Again, looking at health education with these "salutogenic" eyes and the models presented in this book, further adding the strong salutogenic evidence base leading to healthy outcomes it is obvious the salutogenic process could be an effective way to deal with health education. From this perspective one finds it hard to understand this thinking and action has not come more to use. Historically health education has been an important pillar for Public Health ever since it developed into a systematic scientific discipline in the first part of the 19th Century. Earlier on health education activities were focused on hygienic aspects and also became part of the school curricula already in the early 19th Century (Butler 2001). There are two parts of the concept, first "health" and, second, "education". Most of the education" activities are not linked to a broad holistic view on health but focus on protection, risk reduction or prevention. There have been different methods and concepts introduced regarding the "education" part of the concept: health*communication*, health*fostering*, health*pedagogics*, health*knowledge*. The latest in line is healthliteracy. This concept has been given many definitions that mainly

focus on the ability to understand health messages or texts and, on the other hand, the ability to navigate through the health system (Nutbeam 2000, 2008, 2009). Out of these definitions perhaps the most comprehensive is given by Kickbusch: "Health Literacy is the ability to make sound health decision in the context of everyday life – at home, in the community, at the workplace, the health care system, the market place and the political arena. It is a critical empowerment strategy to increase people's control over their health, their ability to seek out information and their ability to take responsibility" (Kickbusch, Wait et al. 2005). In fact, WHO at its most recent Global Health Promotion Conference in Nairobi 2009 changed the vocabulary of the health promotion action areas from Ottawa and now uses "health literacy and health behaviours" amending the earlier "Developing individual skills" (WHO, Nairobi Call to Action, 2009). However, in the mind of the public, practitioners and academia the values and understanding of health education has not changed significantly over time. It is still often seen as a method to convey, "teach", health-expert-knowledge on factors to special groups and the general public. There has been little focus on the "health" part of the concept. In the 19th Century the health concept evolved in parallel to the increasing knowledge on what causes illness and disease. It was mainly conceived as the opposite of illness. The health sector saw the education part as teaching patients and the public. This basic view continued up to the middle of the 20th Century. A new opportunity in the development came in the aftermath of the Second World War when the UN and WHO were established and the WHO definition of health, based on wellbeing, was declared in 1948. However, most health education activities continued as before also in the "golden age" of health risk behaviour modifications and interventions in the 1960ies and 70ies. The policy change came after 1977 when the WHO launched its global programmes for health - Health for All by the year 2000 including the aim of "adding life to years" i.e. quality of life and wellbeing (WHO 1981). This included the embryo of health promotion in WHO principle document on health promotion in 1984 finally manifested in the Ottawa charter on Health Promotion in 1986 (WHO 1986). When health promotion was introduced as such a new direction in public health there was another opening for rethinking health and health education (Nutbeam 2009). A new set of values was introduced affecting both the education and health part of the concept. First of all health promotion aimed at involving and empowering the public itself to a much higher extent than before in the activities and decisions involving health. Health was seen as a process over the life span and as a



The interdisciplinarity model for building coherence and community

resource for wellbeing, thus reaching beyond the views of the traditional health sector. Rather than only directing the main education activities towards the prevention of disease and the avoidance of premature death health activities were supposed to be directed towards making health an important resource for life. Although salutogenic research is used in different disciplines education science is seldom involved (Nilsson 2004; Quennerstedt 2006), with a few exceptions such as children with special needs (Lindström 1999) or learning difficulties (Margalit and Efrati 1996; Lackaye and Margalit 2006). A longitudinal study on Japanese university students (Togari, Yamazaki et al. 2008) linked a strong SOC to future good physical and mental wellbeing including a stronger interest in learning. Lundgren (2002) has shown how the SOC concept can be used in a school context developing strategies for students' ability to influence their own situation. Here the ability to construct a set of mind aimed at a stronger sense of reality and comprehension was central. Not surprising the learning process developed as a constant interaction between students and the school environment creating comprehensive and meaningful patterns.

Introducing the salutogenic approach to health education — "healthy learning"

As previously stated the health outcomes for people who generate a strong SOC is a longer life, an inclination towards more constructive health behaviours (exercise, food habits.) less health damaging behaviours (alcohol, smoking, ...) a higher stress tolerance and finally coping more successful with acute and chronic disease. It seems that people who learn how to develop a strong SOC, more or less as a side effect experience a better quality of life and perceived health and better mental health (Eriksson 2007). In salutogenic terms the key seems to be how they themselves in interaction with their settings approach life as a whole and find life meaningful, rewarding and challenging on a deeper level. If health education would use methods on this the outcome probably would be better. The word healthy seems appropriate since it indicates the direction and how people/systems deal with the issue of health. The "setting approach" in health promotion has used this word (healthy city, health promoting schools). Further it has been used in policy making (healthy public policy). The concept of *learning* is used because it is a more empowering, Freire-inspired, concept than education where processing life events, habits and experiences are done in a reflective way (life event are mirrored in previous knowledge and experience, finding what capabilities are available internally or, who and what to engage externally to find a solution. Also being able to project the possible solutions into the future, evaluating what would be best approach in the long run, in the life course. Maintaining the confidence the problem can be solved with or without the support of people and the context. This process develops the action competence (Bruun Jensen and Schnack 1997) giving a broader repertoire to deal with life (Nordenfelt 2000). This is a deep process engaging the whole human experience of life, as such, rather far from traditional health education.

We have tried to compress all the elements of the Ottawa Charter principle document and the salutogenic interpretation into a short list that can be used in practice for

instance if you are evaluating a project or checking you have used all the elements necessary in your own project this should be of help. We have tried it out – it works.

The EASY model

- Focus on *resources* for health
- put everything into *context* (such as child – family – school)
- *process- process- process* – long term thinking
- *quality of life* because it is what makes it meaningful for the target group and gives a hint of what to focus on to make them involved and interested in the issue – a prerequisite for *empowerment*
- *active participating subjects* (Human Rights)

So:

- are you really looking for what resources create health
- are you considering the "target group" in context, i.e. synergy of mechanisms on a higher level helps what you work with
- are you involved in the quality of life Issue
- how is empowerment considered and integrated
- are you trying to build a whole-system around the issue you work with (healthy public policy), are all the mechanisms in place in a long term perspective?
- do **YOU** have the ability to see the inside perspective of the target population/ system, i.e. do you have a sense **FOR** coherence that makes it possible for the target group to develop a sense **OF** coherence.

(For all references see the original book)

To conclude, the ETC experience over 20 years has clearly met the challenges set at the start. It has become a multinational pan European course where several hundreds of young professionals in Public Health and Health Promotion have learnt not only for themselves but also for an understanding beyond their cultural and geographic boundaries now being able to identify the similarities and resources rather than only seeing problems. In one of the first courses one of the students from a Baltic country wrote "I came here because I thought I had a problem but realized it was not only me it was also the so called developed Western European countries that did have similar problems and we learnt how to tackle them together." The ETC has over the years grown from 4 Institutions to 10 institutions, still the basic climate and trust is there. We all learn every time we run this venture. The structure of the course has changed, meeting contemporary demands of efficiency also using modern learning IT technology such as distance learning as a tool for improvement. The learning model used in the course has served as a model for the EU EUMAHP (European Masters of Health Promotion) project that eventually joined the ETC and cooperated in several courses. Now the IUHPE has taken interest and the Global Competencies for Health Promotion Project is using the ETC as a live laboratory for their development. The ETC has grown beyond the European boundaries.

The Story of the ETC Symbol, the Hot Air Balloon

I think all who attended the first ETC courses still are able to remember how we used the hot air balloon as a symbol for the life journey, stating that all of us are equipped, somewhat equally, for this journey. We all have our own balloon but we need to learn to navigate in and with the help of people and the environment. To ride a balloon symbolizes the unpredictability and the skills we can learn in the life run. There was an image/video from a balloon race where hundreds of balloons flying at the same time representing the cooperation needed to make it a good ride for all i.e. enabling the good life on a collective level. The symbol was used when I explained why Quality of Life and wellbeing is a lost dimension in Public Health and Health promotion as an outcome of the health Process. This later became the image representing the principles and values of the Ottawa Charter (FIG 2).

At one point I put all the members of the ETC as passengers in the balloon carriage, the basket. If you look carefully you can identify Alena Petrakova, Paolo Contu, Concha Colomer, Aislinn O´Dwyer, Gordana Pavlekovic, Maria Koelen and Bengt Lindström in the carriage. The question is who is the navigator.

I leave this quiz to you

Bengt

The origin of the 'Hot Air Balloon' created by
© Bengt Lindstrom

El Parto Es Nuestro

Concha Colomer, una gran mujer

abril 9, 2011 por elpartoesnuestro

Hoy es un d'a triste.

Concha Colomer Revuelta (1958 - 2011)

Dear colleagues and friends!

On April 9th 2011 Concha Colomer died suddenly and she has not only left a great sadness but also a great legacy for health promotion behind her.

I am sure you will agree that it is significantly poignant and terribly sad that we mourn the loss of a great woman, a great public health professional and a truly great friend in Concha Colomer.

I met Concha for the first time in Gothenburg 1990 at the beginnings of the European Training Consortium in Health Promotion (ETC). This was a great start of something incredible for health promotion in Europe but for me too, as I started on my own 20-year journey in health promotion. I can genuinely say that without her this initiative to set up an innovative training network to support Strategies for Health in Europe and the worldwide new health promotion movement guided by the well-known Ottawa Charta would not have happened. Concha hosted the first ETC summer course in IVESP Valencia in 1991. Actually Zagreb was selected as the first venue but the civil war and the breakdown of the former Yugoslavia was happening at this time. Concha stepped in and Valencia was the city for the launch of this spectacular resource, now in its 20th year. Concha also hosted the Summer Course in 1993 and again in 2002; the latter was a key milestone for ETC because of the significant achievement of a partnership with EUMAHP, to strengthen the European Dimension of Health Promotion through common efforts that still exist.

Making things happen was one of Concha's great professional abilities. She was always looking for opportunities and new ways for cooperative and collaborative working across Universities, organisations and countries. As a qualified social paediatrician she held a particular interest in the field of health promotion and was committed to improving the quality of life and well being of people in Europe.

From the beginning – Europe was her focus – this is evident from the great number and range of activities she has initiated and developed within the WHO Region of Europe and DG Sanco of the European Commission. There are many examples of key milestones in the history of health promotion where Concha has influenced projects to strengthen the process of capacity building in the field of Public Health and Health Promotion. The annual ETC Summer Course is a legacy to Concha and her colleagues and friends within ETC.

This year we are going to celebrate our 20th Anniversary of ETC Summer Courses in Zagreb. Concha was invited and she was very much looking forward to joining our Symposium about Twenty Years of Capacity Building in Health Promotion – ETC-PHHP Experiences and Future Strategies. The message from April 9 about her sudden death shocked all of us. We miss her and it is a great loss. But she will always be with us. As a result, ETC is pleased to announce the launch of the 'Concha Colomer Award' for innovative learning strategies and approaches within health promotion education and training, in her honour and remembrance.

Concha was an open-minded and always encouraging and particularly strong Spanish woman, hard working but also very much enjoying life. Her full grace appeared on the dance floor when she was dancing Flamenco with Carlos her husband. What a splendid Señora!

God bless her!

Klaus D Pluemer on behalf of the ETC team

Part 3
Reflections on the Last 20 Years by Past Participants

Barbara Battel-Kirk (Galway 2004)

In June 2004 I was a student at the ETC–PHHP Summer School in the National University of Ireland, Galway.

As an independent consultant I am very aware that keeping up to date with current theory, knowledge, research and best practice is very important and that it is possible to become isolated from the support and challenges which working with peers provides. Undertaking continuous professional development is therefore essential. The Summer School in Galway provided a challenging but safe environment for me where I could update my knowledge, explore new approaches, test skills and get constructive criticism from colleagues.

On both a social and professional level I made contact with people from across Europe – some of whom have become work colleagues in a variety of projects over the past seven years. On all levels participating in the Summer School in Galway was a very positive and rewarding experience for me.

Ardita Baraku (Cagliari 2009)

The course enabled me to visit new places, obtain new knowledge, cooperate in a multicultural environment and establish long-term professional relationships. Cagliari was a beautiful town, having active social life and charming local people. The course contained lots of new information conveyed through continuous student participation; this actually resulted in quite a large portion of student work but also in tremendous portion of amusement. The most challenging part of the course was the group work: different professional, educational and personal backgrounds created frequent clashes between the group members. Fortunately, we were all professionals and the desire to succeed united us. The best outcome of the course is the long-term character of the professional relationships created during the time; I maintain contacts with lecturers and participants from the course. To summarise my overall impression of the course in one sentence - I just loved it.

Erika Marie Pace (Perugia 2005)

Summer School, Perugia 2005: pleasant memories of a quaint city, a professional yet lively organising team, a diverse group of participants with one common interest, and a jovial European atmosphere. Could I have started my career in Health Promotion in a better way?

While the distance-learning part was an immersion into the history and best practices of health promotion, the two weeks in Perugia were an interesting mix of hands-on experiences, presentations, creative role-plays, and a guide to the direction we wanted our professions to go. This experience has definitely left its mark on my career path and was also a great opportunity for personal growth, making Health Promotion principles not only a career prospect but also tools for everyday living.

Ewa Iwanow (Cagliari 2009)

The ETC-PHHP Summer School in Sardinia was a truly enriching international experience. I met wonderful people whose knowledge, experience and salutogenic attitude made my learning very enjoyable and rewarding. The course not only developed my interests in mental health, but it also led to conceptualising Salutogenesis and migration in my master thesis. Thank you for a great learning experience and lovely time in Sardinia!

Tibor Santo (Prague 1996)

Although before the summer course in Prague, I have participated at other similar postgraduate educational programs, the ETC-PHHP course was the most complete. This is due to its content and to the rich experience of participants from different professions in the public health field. I mean here both, the teachers and the attendees. Besides adopting skills and techniques for health promotion, exchanging experiences was invaluable, especially with the participants from the so called transitional countries. From the Czech health reform presentation, which was very actual at that time, I gained additional knowledge about the technology of planning and programming on a very specific example. The knowledge and skills achieved were of great benefit in the development of the Osijek-healthy town project where I was a coordinator, as well as in the empowerment of health promotion in the Osjeèko-baranjska County.

Aleksandar Džakula (Valencia 2002)

The ETC course represents a special learning experience – on the same place participants are exposed to expert knowledge and proficiency of the teachers as well as to the peer evaluation of their ideas, approaches and knowledge. All of it can then be applied in the development of their projects.

Zlata Jaška (Cagliari 1997)

Now, after more than a decade from my ETC course attendance, the memories rouse in me beautiful associations. We worked hard, both as a team and independently. Support and collaboration were strongly felt. I specially remember when all of us individually presented our projects with posters compiled in late night hours... different countries, cultures, problems, priorities, and various creative solutions, but one common enthusiasm and the same goal - health promotion for a better world.

For me it was one precious and beautiful experience outside the frame of our Croatian reality.

Ivana Pavić Šimetin (Zagreb 2006)

I participated at the ETC-PHHP summer school in the year 2006 when it was held in Zagreb. It was a hot and sweltering Zagreb summer. While others were sailing on the Adriatic Sea, we were navigating on some new seas of health promotion. In a friendly community and incentive atmosphere, with a lot of assignments which we had to solve in bigger or smaller groups, days were passing quickly, even too quickly. We learned from competent lectures as well as from each other because it is rare that one can find such diversity in professional fields and geographic area working and acting on one spot.

Sanja Kušec Brangan (Zagreb 2000)

Even though it has passed 10 years since I participated at this course the memories are still vivid. It was very interesting, active, even demanding – we travelled from Zagreb to Dubrovnik to the other part of the course. I was given the opportunity to train my presentational skills, refine my knowledge but also to discuss professional dilemmas of my research project just in time when I needed it most, not only with the teachers who were always ready to converse, but also with other attendees. It was a precious experience, but in the same very entertaining and fun.

Asja Palinić Cvitanović (Valencia 1991)

I remember Valencia and the ETC program in year 1991 very well. My presentation, where I talked about my project, I ended with the music spot "STOP THE WAR IN CROATIA". Even though somewhat frightened because of the beginning of the war in Croatia, upset because some couldn't understand my worries and pain, I returned back home even stronger and with more capacity to fight with the war fright. Many were connected to us in thoughts, with good desires, and specially a big thank You to Mister Alf Trojan for all the aid which he sent to my anguished country.

However, I managed to realize the planned program (TOGETHERNESS-A SEXUAL EDUCATION PROJECT FOR ADOLESCENTS) and to present the excellent results on the III Croatian Congress of School and University medicine in Zagreb in year 2001.

Matija Čale Mratović (Valencia 1991)

My name is Matija, I am director of the Institute of Public Health of the Dubrovačko-neretvanska county - the most southern county in Croatia. In year 1991, I participated at the first European Training Consortium course in Valencia. There, I was working on the project how to teach social skills to children and youth. I wasn't event dreaming that not even two months later I would have to take care of problems such as how to provide and organise the delivery of medicines for the sick, milk for the mothers with babies, transfer of the wounded to the nearest hospital, where to bury the killed in war

in the detached Dubrovnik suburb called Mokošica. Even less I could imagine that on the ship full of refugees, in the middle of the Adriatic Sea, I would deliver two babies.

The period which followed, fraught with fast and great changes demanded new answers for the assessment and the way of dealing with population health requirements, especially of little children. The experience that I have gained in Valencia, the feeling of belonging to one big group of people who care for the community welfare and wellbeing, for health and people above all, was of priceless value to me. It provided me a feeling of competence, power, and connectedness which I felt even during the time when the city of Dubrovnik was an island and I was running a big number of different activities and programs; from organising psychosocial help for the refugees and children, care for the wounded children, program to prevent land mines and explosive devices victims, to the creation of school preventive programs (addiction prevention and school violence prevention) and later many other programs.

Today, looking back these 20 years ago, I can openly admit that this First ETC course grounded the key public health skills and directed my future professional path and my devotion towards public health goals.

Part 4

The Impact of ETC on Professional Practice

The Impact of ETC on Professional Practice

Sharing Experiences in Developing Competencies, Standards and Accreditation for Health Promotion

Barbara Battel-Kirk

Introduction

Since participating in the ETC Summer School in Galway, Ireland in June 2004 the majority of my work has focused on competencies, standards and accreditation for health promotion. I am currently the project coordinator for a pan European project 'CompHP -Developing Core Competencies, Professional Standards and Accreditation for health promotion in Europe'. This work builds on previous experience on the development of occupation standards for health promotion and multidisciplinary public health gained in the UK.

Attending the 2004 summer school gave me an opportunity to make contact with colleagues interested in furthering the competency approach at both global and European levels.

Since 2004 I have been involved in some key developments in relation to competencies and standards for health promotion. This included participating in the development of the consensus statement: Toward Domains of Core Competency for Building Global Capacity in Health Promotion: The Galway Consensus Conference Statement (1). This statement evolved from collaboration between the International Union for Health Promotion and Education (IUHPE), the Society for Public Health (SOPHE) in the USA and other partners which aimed to promote exchange and greater collaboration on the development of core competencies in health promotion and the strengthening of common approaches to capacity building and workforce development. The Consensus Statement drew on a number of papers prepared for the conference, including a review of the international literature on competencies and their development (2) and on existing accreditation frameworks in Europe (3).

Based on the literature reviewed, the following recommendations were made for developing internationally agreed core competencies:

- Agree definitions of health, health promotion and the principles and values that will underpin the framework.
- Agree the methodologies by which the competencies will be developed and validated. It is suggested that multiple methods be used to capture the complexities of health promotion.
- Consider the degree to which consensus can be sought from a large and diverse group of respondents while maintaining ethically sound and meaningful competencies.

- Explore the best formats to ensure that the competencies are clear, meaningful, robust and succinct.
- Ensure that the development process is clear and transparent and that the health promotion community as a whole has a sense of ownership of the core competencies.
- Analyse current trends and forecasted changes within relevant environments to ensure that the competencies are appropriate for future practice and workforce planning.
- Be aware of the differing levels of health promotion development between and within countries and regions, and of the diverse cultural, social and political contexts.

Finally, it was recommended that competencies should identify what is specific and unique to health promotion and the theoretical, research and ethical principles which underpin its practice (2).

The international literature on competencies for health promotion provides valuable insight into the differences and commonalities across frameworks and development processes which can be used to inform the development of effective core competencies at international level.

The review concluded that in identifying the way forward it is important to take account of current and future health promotion challenges, the diversity and trends within

Discussion after Field Visit in Zagreb 2006

the health promotion workforce, and the rate of development of health promotion policy, knowledge and infrastructure globally. Developing consensus on the core competencies in health promotion was identifying as serving as a useful basis for strengthening workforce capacity building and thereby contributing to advancing the quality of practice, education and training globally.

Following on from the 'Galway Consensus Statement' a pilot feasibility study on implementing a pan-European accreditation system (4) was undertaken by the IUHPE with participants from seven countries. The participants endorsed an accreditation framework which describes a voluntary accreditation/ registration system based on an agreed set of competencies and professional standards.

The countries who participated in this study, together with other partners, formed a partnership to develop a proposal for funding for to develop competency-based standards and a pan-European accreditation system to the European Agency for Health and Consumers (EAHC). The rationale for this project referred to the global experiences in competency development for health promotion as described in the literature and to other drivers including; freedom of employment policies highlighting the need for agreed standards to facilitate employment across the EU; quality assurance issues for practice, education and training identified within all health fields in Europe; and clarity on workforce capacity required for promoting health and addressing inequalities as identified in EU strategies – all of which can be best addressed through agreed competency- based standards. The application for funding was successful and the CompHP Project commenced in September 2010.

Working with the CompHP project partners, both in developing the project proposal and as project coordinator, has been my main area of practice in the past two years. The CompHP Project has just passed its halfway point and a number of key publications are already available (5,6,)

As well as having the satisfaction of seeing the CompHP Project come into being and meet its aims, from a personal professional perspective, my recent experiences have widened my understanding of health promotion, given me opportunities to work with colleagues from many countries and allowed me contribute to some key initiatives in the development of competencies, standards and accreditation as tools for capacity building in health promotion. I am very pleased to again be able to share these experiences and make contact again with colleagues at the Summer School Symposium in Zagreb.

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Low-Educated Employees and Health Promotion

Nataša Dernovšček Hafner

Introduction

This paper presents empirical data collected from a sample of Slovenian employees as part of LEECH (Low-Educated Employees towards Health), an international research project funded by EU Commission within the Grundtvig sub-programme: the Life Long Learning Programme, that took place in four European countries: Latvia, Poland, Spain, and Slovenia.

The purpose of this study was to determine the competencies and needs of various employee target groups regarding health, their willingness to change their lifestyles, etc. It thus provides the basic information needed for planning concrete occupational health measures (employee health-promotion and health-education programs).

Methods

Participants

The research data were collected from a sample of 402 Slovenian employees working at companies in the major Slovenian towns. The sample was selected under the criteria that the best identify a specificity of Low Educated Employees in comparison to the groups with high education status. In terms of education, the sample was divided into four groups. Half of the respondents (Group 1, Group 2) had less than a secondary education. The other half of the respondents (Group 3, Group 4) had at least a secondary education. The share of men and women in the sample was the same.

Instruments used

The questionnaire, developed by partners in the project, composed of 39 multiple-choice questions was used to measure the health-related competencies of low-educated employees. The questions were combined into six topics: (1) foundations of vulnerability: health, education, and financial status; (2) knowledge and literacy concerning ways of taking care of health: subjective and objective aspects; (3) employees' health behaviour; (4) employees' beliefs concerning a healthy lifestyle; (5) employees' attitudes towards occupational health; and (6) employee's attitudes towards health education.

Procedure

The study was carried out using the "paper and pen" method. The survey was conducted in Slovenian households from 17 to 29 September 2009. The data were analysed using the SPSS software. Differences between the groups were established using a chi-square test.

Results

Foundations of employees' vulnerability

According to the results of the national study, there are no significant differences among the education groups regarding the assessment of their own health. More than 70% of respondents stated that they were in good health.

The employees with the lowest education were more likely to have suffered an injury or have had a disease in the previous year that affected the performance of their daily activities at work or at home, and to have had a chronic disease requiring regular medical check-ups.

Employees with a secondary, undergraduate, or higher education tend to learn languages and acquire computer skills faster, easier, and in larger numbers than lower-educated employees. In addition, they tend to broaden and improve their knowledge related to their occupations or hobbies.

Low-educated employees have a lower financial status than higher-educated respondents. Nearly half of the respondents from the primary education group reported they had to live quite modestly, whereas in the graduate education group only 10% of respondents replied the same.

Knowledge and literacy concerning ways of taking care of one's health

Self-assessment concerning ways of taking care of one's health

Employees with a secondary education or higher are more likely to assess their health knowledge as "very good" or "good" than low-educated employees ($p < 0.001$, $\chi^2 = 51.0$, $df = 12$).

Fifty-six percent of the respondents would like to learn more about how to take care of their health and 30% believe they know enough. There is a statistically significant difference between the education groups: higher-educated employees are more likely to want to learn more about how to take care of their health than lower-educated employees ($p < 0.05$, $\chi^2 = 13.3$, $df = 6$).

Health literacy

The respondents' health literacy was determined by assessing their knowledge of some basic health-related terms such as passive smoking, illness prevention, healthy lifestyle, the food pyramid, body mass index (BMI), and cholesterol.

The respondents knew and understood the terms well (more than 77%). There were

statistically significant differences between the education groups concerning all topics except the food pyramid and cholesterol. In all the other cases, employees with a secondary / junior college and tertiary education proved to be more health literate than lower-educated employees.

Perceived employee needs for health education

Forty-five percent of respondents believed that what Slovenians generally need the most is to learn how to cope with stress. Forty percent of respondents said that people should be educated about the importance of getting regular exercise, and 37% felt the need to be informed about the importance of check-ups for early detection of diseases. Taking better care of one's health seemed important to only 8% of the respondents. There were no statistically significant differences between the various educational groups.

Employees' beliefs concerning a healthy lifestyle

Employees with a secondary / junior college, undergraduate, or higher education were more likely to follow health-related information and think about how to lead a healthier lifestyle ($p < 0.001$, $\chi^2 = 37.8$, $df = 9$).

Employees' attitudes towards health education

Motivational factors for participating in health-training courses

Figure 1: Share of positive responses regarding the attractiveness of motivational factors for participating in courses/workshops

There were no statistically significant differences between the various educational groups.

Factors that would discourage respondents from participating in a health-training course include the following: the need to pay for the course (66%), the need to speak in front of a group of people (40%), a course lasting more than two hours (34%), and a

final test (33%). Statistically significant differences between various educational groups were found in relation to the four factors. All of them would discourage a larger share of employees that had failed to complete primary school or with only a primary or lower secondary education from participating in these courses than of those with a secondary / junior college, undergraduate, or higher education.

Finally, employees that had failed to complete primary school or with only a primary or lower secondary education are more likely to be discouraged by their concern that they would have difficulties understanding the instructor than those with a higher education.

Discussion

A number of studies confirm the connection between socioeconomic status and health. People with a lower education, lower income, and lower occupational status tend to have poorer physical and mental health and a shorter life expectancy than those with a higher education; in addition, they tend to use available healthcare services and preventive programs less frequently (5).

The study determined that more than 70% of employees assessed their health as "good." The trend of more frequent chronic diseases among employees with the lowest education corresponds to the findings presented in international literature (1).

More than two-thirds of employees assess their health knowledge as "good" or "very good." More than half want to know more about how to take care of their health. The fact is that the employees with the highest levels of education—who, as the results show, are also more health literate—in particular want to learn more about health issues. The results confirm the findings presented in literature that health-education and disease-prevention programs have a stronger effect on informed and better-educated participants (2).

With regard to ways of learning more about health, low-educated employees found watching TV and listening to the radio the most preferable; this is a passive form of acquiring knowledge. However, we believe that 56% of the respondents stating that they want to learn more about their health is a good basis for organizing training courses in companies aimed at improving health. It should be especially determined how to attract employees with the lowest levels of education. Given the results, we recommend training adapted to individual participants (e.g., free training courses/ workshops shorter than two hours etc.), and adjusted work methods and teaching approaches (e.g., written tests replaced by other forms of examination).

Coping with stress proved to be the most interesting health-related topic that people would like to be informed about, which is not surprising. Workplace stress is becoming a major problem for companies in the twenty-first century (3). Health-promotion programs are achieving good results in stress management (4).

Free courses are a strong cross-national factor for people to participate. The need to pay for these courses would discourage two-thirds of respondents from participating;

among these, employees with the lowest levels of education would predominate—the ones that would actually need this training the most.

A final test and speaking in front of a group of people are important discouraging factors for employees with the lowest level of education. What comes to the fore with this group, is in author's opinion, fear of failure and external control.

An important goal of health promotion is to make it available to people (4). This is why, in planning health-promotion programs for low-educated employees, it is especially important for them to be adapted to the needs of the participants and for their goals to be realistic and feasible.

Farewell Dinner on Board of an old Sailing Boat, Bergen 2008, at the last day

Conclusion

The research findings provide extensive insight into the needs of various employees target populations, thus indicating opportunities to develop an employee healthcare strategy and plan concrete measures for improving occupational health.

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A Workshop on Using Film and Photography in Health Promotion

Christine Clar, Gudrun Faller

Introduction to the topic: identification of needs

In a multi-media society, where we are bombarded with images every day and where anybody can have the means of photographing or filming anything, we need to develop a form of critical visual literacy. At the same time, using a range of visual methods in health promotion has the potential to: a) contribute to reaching diverse target populations, b) contribute to giving target populations a voice, and c) provide valuable research tools. Teaching health promotion students visual literacy and acquainting them with methods of using film or photography in their area of work will provide them with useful skills in their future role as health promoters.

Objectives: purposes of the work

To describe a workshop on possible uses of film (and photography) in health promotion for a group of Masters Students following a course of "Health Promoting Organisational Development" at Magdeburg-Stendal University of Applied Sciences (Germany).

Description of what was done

This one day workshop consisted of a morning part comprising theory and discussions, and a practical photographic project in the afternoon. In the project, photography rather than film was used because of the short time available, but projects that were devised such that they could also have been carried out using film. The students and the responsible tutor gave their permission for any photos taken to be used in the current document. Due to the context of the Masters course, a particular focus of the workshop was on workplace / organisational health promotion.

The first part of the workshop included discussions with students asking whether (and if so why) we need more images in a multi-media society, and how we can map out the field of film in interaction with the field of health promotion (using an interactive mind map technique). The following broad topics were covered in the workshop: a) Historical aspects: the invention of photography and film and early use in science and for bringing about social change and health improvements (e.g. the work of Lewis Hine for the US National Child Labour Committee from 1908), b) Visual anthropology / ethnographic methods and using film or photography in the context of qualitative research (Pink 2007, www.healthtalkonline.org), c) social marketing and media advocacy (Hastings 2007, Wallack 1993), d) participatory methods and

empowerment (Flum 2010, White 2003), e) use of films in training, education, health promotion programmes etc.

In preparation for the practical part of the workshop in the afternoon, some issues regarding picture composition and film structure were discussed. It was planned that for the practical part of the workshop, the students would split up into three groups and each group would carry out a photo project (using small digital cameras) under the general theme of "university as a place of work", with each group focussing on a different method discussed:

a) using photography in a participatory process (photovoice): in this case, the students themselves were the participants who were to be empowered to bring about changes in their university working environment
b) using photography as a qualitative research tool (photo elicitation): students were to take photos relating to the university working environment and interview their tutor (i.e. a university employee) based on these photos, and
c) creating a photo story under the heading of "social marketing" or "media advocacy": students were to think of a relevant topic in university work-related health promotion and develop a photo message ("advertisement") for a relevant campaign.

However, as during the workshop all students had a strong interest for the participatory project, it was decided that the three groups would all work on the same subject, allowing a direct comparison of different approaches to the same method. Students were encouraged to regard the photography as part of an overall scientific process and to spend time on thinking about aspects of project planning, stakeholder analysis, and project evaluation. The work was subdivided into a planning phase (where the groups decided on a specific topic within the theme and developed a strategy), a practical phase (where the groups carried out their plans, taking photos etc.), and a phase for preparing a short presentation using the material collected in the practical phase. The groups then each had time for a short presentation and some discussion of their experiences. A period of general discussion and feedback concluded the workshop.

Discussion of what was achieved and how the work has advanced our understanding of the topic

The students gained an overview of a range of different ways of using film and photography in health promotion – as a tool for research, and as a tool for facilitating change. The students valued the workshop and the information provided, especially the practical examples and references given; they greatly enjoyed the practical part of the workshop and said that they experienced how photography could be a powerful tool for getting ideas across.

In their projects, one group particularly focussed on working conditions in the library, while the other two groups focussed on studying in general. All three groups raised similar concerns. In their photographs, students highlighted positive health promoting aspects of their university life, such as a green environment, companionship and sporting facilities:

On the other hand, they also identified a range of stress factors, such as limited opening times of a range of facilities and limited availability of staff for consultation:

Other concerns included workloads at peak times, unfavourable workspace design in the library and perceived lack of library stock:

Conclusions: take-home messages

Providing students with some insight about ways of using photography and film in health promotion has given them additional tools for bringing about change in their later practice. The experience of the workshop and the feedback from the students have highlighted areas of the workshop that could benefit from improvement, such as:

1) Relevance of theory for practice: the students found some of the background material not directly relevant to their area of study, and one problem was probably the attempt to try to cover too much material in a short period of time; possible solutions: a) a longer workshop with more room for interactive discussion of the relevance of issues and with thinking about ways of applying them to use in health promotion, b) focus on key areas and discussing these in more detail with respect to application in health promotion, c) providing some background details in hand-outs rather than as part of a detailed talk.

2) Interaction and discussion on topics unfamiliar to the students and making links with issues already familiar to them: while the mind map method was meant to provide an overview of the whole field, students felt that too much time was spent on topics already evident to them; possible solutions: a) transforming some of

the overview work of linking old with new into group work (e.g. asking what film methods could be used to facilitate different aspects of the Ottawa Charter or the Luxemburg Declaration; what film techniques / formats could be used when using different visual methodologies etc.).

3) Use of a range of different techniques in the practical projects: students all preferred the same project; possible solution: using a systematic way of dividing students into groups and allocating projects to groups.

4) Thinking in terms of scientific projects and processes: students greatly enjoyed the photography, but only one group presented thoughts about stakeholders and evaluation in some detail; possible solutions: a) emphasise more the points to be covered in the presentation; b) in a longer workshop, students could also present planning and practical phases of the project separately (i.e. presenting a project "protocol" before carrying out the visual work).

5) Involvement of external participants in projects: the workshop took place at a time when the campus was largely empty, so the projects had to be devised so that they could be carried out by the students largely alone, with only their tutor being available for interaction, but no other representatives of different staff groups; possible solution: arrange the workshop such that there are opportunities for doing projects in interaction with different groups of university staff (or others as appropriate).

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Life Experience of Older Immigrants Living in Sweden and Receiving Municipal Care

Boel Hovde, Ingalill Rahm Hallberg, Anna-Karin Edberg

Introduction

In Sweden older immigrants in need of public health care will increase in the future. It is therefore important to increase the knowledge of their situation in order to meet their varying care needs.

Objectives

The overall aim was to explore the situation of older immigrants, aged 65 years and older, living in Sweden and receiving municipal care with a focus on care provided care-related needs and their experience of their life situation. The specific aim was to illuminate the experience of the life situation in the context of receiving public care among older immigrants.

Methodology

The approach was qualitative and interviews were performed with 16 older immigrants. The transcribed text was analysed using qualitative manifest and latent content analysis.

Discussing Words in the Terminology-Session with Gordana Pavlekovic, Wageningen 2007

Results

The overall impression in the older immigrants' narratives was 'Owing a debt of gratitude to Swedish society', as the older immigrants were grateful to the society that had taken care of them and provided satisfactory care and service. The prevailing impression of their stories was that they did not want to be viewed as being ungrateful. The immigrants' experience of their life situation in the context of receiving public care and service could be understood in four categories: Being burdened with health complaints, embracing the experience of having physical as well as mental complaints that affected their everyday life; Experiencing painful losses, including having to live with history, being outside the familiar context and waiting without a future; Wanting to manage by oneself, where caring was seen as a family matter and they did not want to be a charge to anyone; and Feeling exposed and deserted, meaning being limited by language barriers and experiencing that nursing staff just passed by.

Conclusions

It is thus important to be aware of the older immigrants' vulnerable situation, in the context of municipal care, and to take into consideration the need to recognise aspects related to language, life history and the familiar context.

The Health of Migrant Workers in Slovenia: Results of a Pilot Study

Katja Draksler

Introduction

Global migrations have doubled over the past 50 years. An estimated 200 million people are living outside their countries of birth. The demographics of migration indicate even greater increases in the future, while aging of the population in developed countries will require more immigrants to perform work (Schenker, 2010). In fact, work (and the accompanying economic opportunity) is the greatest driving force for migration in the world. This is also the case for immigration to Slovenia, a country where people of many surrounding countries perceive economic opportunities as good. Statistical data show that in 2009 approximately 13% of Slovenia's working population was from foreign countries (SURS, 2010a).

Migrant work significantly benefits not only the economies of receiving countries, but also the economies of countries of origin. The World Bank estimates that global migrants annually send home USD 300 billion in remittances (Schenker, 2010). On the other hand, the costs of migrant work are often hidden because they usually affect migrants themselves. This is also true in the case of the (ill) occupational health of migrant workers.

Migrant workers are mostly employed in particular sectors. A very small percentage of them are employed in high-skilled professional jobs, but a much larger percentage in "three-D jobs" (dirty, dangerous, and demanding). These are jobs that are more easily accessible to migrant workers because the native population is often unwilling to accept them. This kind of work is often characterized by high workload, poor working conditions, and low wages, and at the same time it carries much higher occupational risks for the health of these workers (EU-OSHA, 2008; Medica et al., 2010).

The occupational health burden of migrant workers is often overlooked. A recent document from European Agency for Safety and Health at Work (EU-OSHA), that summarizes the current knowledge on the occupational health of migrant workers in European Union, concludes that although the knowledge on migration, health and working condition exists, efforts that bring these three areas together are limited (EU-OSHA, 2008). Consequently there are not many data available on migrant workers' health, but the existing data show higher occupational morbidity and mortality among migrant workers (EU-OSHA, 2008; Schenker, 2010). All this clearly implicates that this field needs to be studied further.

Objective of the study

The Clinical Institute of Occupational, Traffic, and Sports Medicine (CIOTSM) carried out a pilot study on the health of migrant workers in Slovenia. The pilot study was conducted in May 2010 at one of the largest residence halls for single persons (workers' dormitories) in Ljubljana with approximately 250 residents. Our main objective was to investigate living and working conditions of migrant workers in Slovenia with special emphasis on occupational health and safety issues. The results gathered in the pilot study would give us an insight in the situation of migrant workers in Slovenia needed for designing a broader study on the field.

Maria Koelen in an interactive working session, Wageningen 2007

Methods

The main instrument used in our pilot study was a questionnaire with 67 questions about socio-demographic data, living and working conditions, life habits, health status (self-reported health), present and previous employment, and health and safety at work. Because most of the migrant workers in Slovenia come from some areas of the former Yugoslavia, especially from Bosnia-Herzegovina, the questionnaire was translated into Bosnian language.

The fieldwork was done by members of CIOTSM staff, one colleague from the Association of Free Trade Unions of Slovenia who helped us to access to migrant

workers, and two volunteers. The questionnaires were distributed personally by members of our team to the workers in the dormitories rooms and collected after one hour by the same team. The purpose of the study was explained to every worker while distributing the questionnaires. Workers were asked to fill in the questionnaire by themselves but the members of our team were available for possible questions nearby.

Though we expected workers will be working long hours and went to the dormitories in the evening hours, many of workers still did not come home from work. Subsequently we collected 95 questionnaires; two of them were excluded later. While Bosnian workers represent the major part of migrant workers in Slovenia the questionnaire was translated only to Bosnian language. This was later proved as a weakness while we were unable to collect some questionnaires from migrants who did not understand Bosnian language (workers from Albania, Kosovo and Bulgaria).

Results

The sample in our pilot study included 92 foreign male workers mostly from Bosnia-Herzegovina. Fifty-four respondents had graduated from a vocational school, 24 from secondary school; eight had less than a vocational school education, and four had a higher education. Two respondents gave us no answer to that question.

The monthly income of 57 of the respondents was between EUR 500 and 1,000, whereas 33 respondents received less than EUR 500. Two respondents gave us no answer to that question. Average monthly net earnings for May 2010 in Slovenia amounted to EUR 956,55 EUR (SURS, 2010b). The respondents usually use the money they earn to support their families back home (in their country of origin).

One-third of the respondents reported that they usually receive part of their salaries under the table in cash, which is illegal. In line with the Labour Inspectorate of the Republic of Slovenia reporting on common occurrence of this “under table paying’s” especially to the migrant workers (ZSSS, 2010), we anticipated that this number could be even bigger while there is possibility that some of the respondents were afraid to report about it.

Because language is often considered a barrier to achieving, maintaining, or improving the level of health and safety at work, we also asked them about their ability to communicate in Slovenian. Sixty-three respondents understand but cannot speak Slovenian, 8 understand and speak Slovenian and 20 can speak and write Slovenian. One respondent gave us no answer to that question.

One-fifth feel that living conditions in the workers’ dormitory are very poor, whereas almost half of the respondents said that the living conditions are average, except for the lack of laundry options because they do not have a washing machine.

We also asked them about their habits: 32 respondents smoked tobacco, 20 drank alcohol, while none reported use of illegal drugs. Most of them slept 6 to 9 hours per night and eat only twice a day, and so they have very unhealthy eating patterns.

All of the legal migrant workers are residing in Slovenia on the basis of a work permit. Three respondents had a seasonal work permit, 22 had an employment permit with a maximum validity of 1 year, 29 had a personal work permit with a validity of 3 years, and 37 had a work permit with unlimited validity. The type of work permit that an individual worker has is conditioned by his previous employment. For example, a worker can apply for a 3-year personal work permit only if the same employer employed him for 2 years. Not surprisingly, most of the respondents had been working for only one employer.

We also asked them about the size of the company they worked for. Twelve respondents are working for a company with fewer than 10 employees, 29 for a company with 10 to 50 employees, 22 for a company with 50 to 250 employees, and 27 for a company with over 250 employees. Two respondents gave us no answer to that question. They mostly worked 8 to 11 hours per day, including during the weekends.

We were also interested in health and safety at work. The results show that 50 respondents were familiar with occupational health and safety risks at their workplace, whereas 35 respondents were not. Seven respondents gave us no answer to that question. More than half of them also did not have any kind of training in occupational health and safety. Fifty-seven respondents regularly received personal protective equipment from their employers, most of them with instructions on how to use it, whereas 31 did not receive any equipment. Four respondents gave us no answer to that question.

We asked our respondents to assess their own health. Thirty-two respondents thought that they were healthy, 53 had minor health problems, two saw themselves as seriously ill and five respondents gave us no answer to that question. They also thought that their health problems were connected to the work they do and that their problems were growing worse because of it. Their main health problems were back pain, injuries, fatigue and exhaustion, high blood pressure, and cardiovascular diseases. Most of the respondents had health insurance and had a medical examination before they started working in Slovenia, where they have regular medical check-ups.

Injuries are a major problem in Slovenia. Thirty-nine respondents report that they had already injured themselves at work, one-fifth so badly that they had to go to the hospital. Considering sick leave, the situation

Who built the highest tower? Team Building Session, Wageningen 2007

18th ETC-Course, 7th in cooperation with EUMAHP, Cagliari 2009, Italy

appears different. Because migrant workers are often afraid of losing their jobs and income, they usually do not take sick leave. Fifty-six respondents had not taken sick leave for the last 2 years.

Finally, we asked the respondents what worried them the most. Their answers included job insecurity, stress at work, negative attitudes of their superiors, poor relations with co-workers, retirement, and the fact that there is less and less work for them. This last worry was in fact quite justified because given the collapse of the construction sector in Slovenia and consequent job losses, around 15,000 migrant workers left Slovenia in 2010.

Conclusions

The results of the 2010 CIOTSM pilot study show that most migrant workers in Slovenia live and work in circumstances that are harmful to their health. They also have a very unhealthy lifestyle, which represents an additional risk to their health. The findings regarding their health problems and injuries confirm this.

The results of our pilot study are not representative of the entire population of migrant workers in Slovenia, but they offer important insight into the situation before the global crisis and the collapse of the Slovenian construction sector. We anticipate that the real situation is even worse while our pilot study was conducted on a small sample of workers in one of the (by workers' opinion) better settled dormitories in Slovenia. We namely got some important information on that (while conducting the field work), what additionally confirmed our assumptions that a more elaborated

research is needed. We have to take into account also the fact that all data gathered in the pilot study is actually based on subjective assessments and opinions of migrant workers themselves. Since they came from a different background to a new setting it is possible that they may have different (maybe lower) expectations so their real living and working conditions could be much worse. Anyway they usually do not have many healthy options to choose while they have very restricted resources as is seen also from our pilot study results.

Although our study sample was small the results are of significant importance for us while there were no data existing in Slovenia on that issue. The pilot study therefore undoubtedly represents an important point of departure for CIOTSM future work because we are planning a project in the near future to collect more data on migrant workers' health and to prepare guidelines to better protect the health of this vulnerable group.

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The Fit for Work Programme of Slovenia

Klavdija Besednjak, Tanja Urdih Lazar

Introduction to the topic: Identification of needs

Slovenia doesn't have an umbrella Health Promotion strategy, only partial strategies were prepared. In the past two decades, the National institute of public health, in cooperation with regional institutes, contributed a great deal to the health promotion development. In the past few years, the Clinical Institute of Occupational, Traffic and Sports Medicine (CIOTSM) made also a significant contribution to continue this work in the field of workplace health promotion.

The Act on safety and health at work was adopted by the Slovenian Parliament, in line with EU legislation, in July 1999 (1). It defines general principles for safe and healthy work at the level of enterprises, employer's responsibility for assuring safety and health at work and workers' duties. A new act is now in the enactment process.

A National Programme of Safety and Health at Work was approved in 2003 (2). It mentions workplace health promotion as an informal measure at the national level and sets the following workplace health promotion goals:

- to enable the development of healthy and safe workplaces;
- to preserve workers' ability to work, to reduce early retirement and sick-leave;
- to prevent injuries at work, work-related diseases and diseases caused by unhealthy working environment, lifestyle and social determinants;
- to preserve a good balance between economic interest and working ability;
- to preserve life environment in general;
- to enable the production of healthy and environment-friendly products.

In this context, the *Fit for work* programme was planned in 2004 on the basis of statistical data about workers' health and due to the fact that there was no such a programme existing in Slovenia at that time. In Slovenia, the most common cause of work absence are musculoskeletal diseases, then injuries outside work and those work-related, followed by mental and behavioural disorders. According to the age groups, those younger than 19 are mostly absent from work due to injuries, same as those between 20 and 44; older workers, between 45 and 64, are primarily absent due to musculoskeletal diseases (3).

Objectives: purposes of the work

The *Fit for work* programme is carried out by CIOTSM and its purpose is to influence employers and workers to gain knowledge and skills for healthy work and life and to introduce into the working environment changes that benefit health. In the long-

term, this should lead to a better workers' health, a gradual reduction in sick leave, prevent injuries and work incapacity and reduce regional differences, while at the same time contributing to greater satisfaction in the workplace and thereby increased productivity and general welfare of the active population.

Description of what was done

Development and implementation of the programme was divided into three stages: in the first stage a survey on managers' beliefs about health and health promotion was conducted in 2005. In the years 2006 and 2007, the content and methodology of the programme was developed within the *PHARE Lifelong learning project*. PHARE was the financial instrument of the pre-accession strategy leading ultimately to the accession to the EU of the ten associated Central and Eastern European countries; it was oriented to numerous fields of action, lifelong learning was one of them. From the year 2007 on, the programme has been implemented.

Group Work in the Team Building Session, Wageningen 2007

The programme covers eight educational modules for areas which are, according to data, the biggest threats to workers' health. In line with the programme recommendations, companies should first conduct an analysis (module no. 1) of workers' health and, on the basis of the results, select the problems to be resolved with one or at most two of the following modules: prevention of injury, ergonomic measures, prevention of burdens due to chemical pollutants, organisational measures, control of stress, prevention of the use of psychoactive substances, and prevention of workplace bullying.

Every year, the Institute organises training for workplace health promotion advisors that come from different companies and institutions interested in improving employees' health. The training takes 10 days for lectures and workshops; additional time is also devoted to personal study for a final exam and to prepare a paper involving an analysis of health status in the organization as well as developing a precise plan of activities to implement according to the main health problem identified. As of May 2011, around 100 advisors had completed this120-hour educational programme and additional 20 will finish training this year.

After returning to their organization, advisors are expected to organize health groups (one or more according to the size of the organization) and provide them with knowledge and skills for implementation of the programme developed during their training. According to the programme, health groups should include people from the following groups of: the workplace health promotion advisor (who coordinates work of the group), company management, workers (works council representative or trade union representative), company doctor or specialist in occupational health (in Slovenia, companies mostly contract this job to external enterprises), occupational safety expert, human resources department and other employees according to the needs of the company.

In addition to the health promotion programme, the Institute prepared a draft concept for a network to promote health at work, which is still in the process of development and is meant to facilitate expansion of the programme in companies. This network will link at various levels all organisations and individuals that can in any way contribute to improving the health of workers and the development of health promotion at work in Slovenia. For now we organise yearly meeting of advisors, where they can gain additional knowledge or just share experience with other advisors.

The programme is supported by numerous tools, including a website on health and safety at work (http://www.cilizadelo.si/), a handbook for promoting health at work and information-teaching materials that advisors use in their work (a booklet, a leaflet, a poster and a DVD). The Institute also provides counselling for advisors who completed training when they start working in their organizations.

Discussion of what was achieved and how the work was advanced our understanding of the topic

Beside the *Fit for work* programme there are some other activities in this field carried out by the Ministry of Labour, Family and Social Affairs that acts as a National Focal Point concerning the co-operation with the European Agency for Safety and Health at Work as well as regional institutes for public health.

According to the feedback from advisors, the most difficult task is to persuade company management to invest into better working conditions. This is the reason why we decided to upgrade our programme with a special campaign targeting company managers. To gain their attention and to raise awareness of investing into employees' health we prepared new materials which were presented at regional and national events for managers. Emphasis of the campaign was that investing into employees' health leads to better creativity, better competitiveness, and higher productivity and to reduction of costs due to absenteeism (4).

The first Slovene research into workplace bullying was carried out in 2008. The results show that 10.4 % of the respondents suffered from workplace bullying in the six-month period preceding the research, 1.5 % of them reported that they have been subjected to workplace bullying. This results confirmed necessity to take actions in

the area of preventing and coping with workplace bullying (5). As a result a module preventing workplace bullying was added to training curriculum.

To asses needs of workplace health promotion advisors, we are preparing an evaluation survey that will be finished this year. The results will help us to strengthen the networking required to promote health at work and to solve problems which advisors are facing during their work.

Conclusion: take – home message

The *Fit for work* programme is the most comprehensive work health promotion programme in Slovenia. Since its beginning in 2007, it educated around 100 workplace health promotion advisors from more than 70 different companies. Those workplace health promotion advisors who are by profession occupational safety experts often offer their services and so disseminate programme to broader circle of companies. Fit for work programme is constantly developing with new modules, lectures for companies and growing network to promote health at work.

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From Salutogenesis to 'Genesis' of Art and Back

Lana Kovačević

Introduction

It was at the summer course ETC-PHHP 1999 in Liverpool that the idea for my master thesis was conceived. The idea was «Salutogenesis», a term which Dr Bengt Lindström talked about in his lecture. The main message of the lecture was that it is maybe more important that someone understands and recognises our uniqueness and authenticity, what we are, rather than «merely» loves us. This sentence led me my research enterprises: first, to writing my masters thesis on the topic of Salutogenesis and then to fine art studies, in which I brought this idea alive using of my own life as an example. The purpose of this paper is thus… to shortly present some highlights of my scientific thesis and of my conceptual pieces and to show how I integrated them. (…to show how I integrated my work of science and my work of art.)

(Medical) Science vs. (Conceptual) Art

During my art degree, I was drawn to the so-call conceptual/intellectual, analytical/ art.

Although there is always a concept of thought behind every piece of art, conceptual art puts the theoretical/philosophical concept in the centre (1). Beside the piece of art – a painting, sculpture, installation, object, ambiance, «body situation», performance or film – there is a text as well, which additionally explains this work of art. The source for the text can be literature, definitions, and theoretical, philosophical or even scientific texts. In art, the theories are used and interpreted in a freer and a more flexible way. Art can nevertheless be exact, focused and precise rather than only aesthetical or sentimental. At the centre of the work of art is the personality of the author and his/her experience; in contemporary theory the topics such as private symbols, personal mythology and similar have been introduced (1). Methodology of modern science is also turning towards individual cases; analysis of a text and it thus comes close to the artistic approach.

Art definitions talk about interdependency between the outside world and the personality of the artist. According to one poetic definition, art is « [a] fleeting balance between discipline of form and cruelty of experience» (2: page 7). Art puts together fragmented pieces and refuse of reality and makes something out of them. Art is «reflection» of reality, construction of shapes or expression of emotions, if those pieces of art are able to inspire, touch or disturb us (3). So, apart from originality and self-fulfilment, the point of the art itself is in an experience of it proposed to the audience, through the art's universality and comprehensiveness.

Salutogenic research

For me, the attraction to Salutogenesis was because of its focus on health, not pathology, as well as its holistic approach towards the resources that lead to health. Salutogenesis is about the origins of health. The main concepts of Salutogenesis are the sense of coherence (SOC) and the general resistance resources.

The SOC is a general orientation to life, and is composed of three elements: comprehensibility, manageability, and meaningfulness. Life experiences throughout childhood and youth form the SOC. Meeting a stressor triggers general resistance resources to cope with it, which leads to a health outcome.

The topic of my master thesis was the development of the SOC. Growing-up without parents is generating many stressors and may lead to a low SOC. The aim of the research was to investigate whether some persons who had been brought up without parental care still developed a reasonably high SOC. It was shown that it was possible; those persons had a realistic, rational and optimistic approach to life.

The results showed that the SOC indeed correlates with (mental) health. Average SOC of the participants of the study was low. Persons which, despite of everything, developed a high SOC, had a realistic, rational and optimistic approach to life. Other persons showed more pessimism, suspicion and a need for a supportive environment. Higher SOC was also associated with higher level of education and employment, which tells us that those factors have a positive impact on the development of the SOC, even later in life (4).

Conceptual art research

My most complex piece – in terms of conceptual development – deals with human relations, communication, fulfilment of wishes and love. Part of the piece is a video in which the performer talks, walking through a landscape, about the impossibility of realisation of love and its absurdity.

Film stills from the video

The theoretical part of the work is based on the psychoanalytical theory of J. Lacan, in which the psychical world of a person is divided into three registers: imaginary, symbolic and real. Imaginary develops in early childhood, when identity is formed on the basis of pictures – one's own reflection in the mirror or comparison with the image of other persons. This picture is in fact alienated and fragmented, uncoordinated. Ego, however, tends to hide this and, with the help of rationalisation, keeps the illusion of sense and wholeness.

Symbolic appears when a person learns language. The person accepts imposed meaning of words or non-verbal signs. Language is, therefore, an alienating network of symbols.

The register of the real does not have the same meaning as it has to do with the everyday meaning of the word. Here, it is something indescribable, frightening, disturbing, enigmatic, outside of the symbolic world of language, as well as of

the imaginary, visual, world. This is a moment in which every usual meaning is deconstructed and the world takes on an unrecognisable shape which can be experienced during intensive, strong emotions (5).

Linking art and SOC

The three registers can be compared with the three components of SOC. Comprehensibility -of the surrounding world -can be seen as the imaginary register, in which a meaning and a connection is added to a fragmented image of oneself.

Manageability – possession of strategies and strengths for coping with stressors – could be seen in the symbolic register. Meaningfulness, the most important element of SOC which drives the other two and from which the motivation for coping with challenges and the feeling that the life is worth putting an effort in comes – can be related to the register of the real. The real is the cradle of meaningfulness and, with its threatening strength, erodes the usual order and accepted values.

Love, about which the video talks, is described, in psychoanalytical theory, through the term of void, lacking. Love is what occasionally erupts as the experience of the real. It exists, but its content is nothing. As such, it cannot be given or received. What is left is only giving the superficial signs of love, simulation of giving oneself, in fact, “lies”, but “beautiful lies”. Love, understanding, friendship, togetherness, seen as some of the most important resources to build a strong SOC, are in fact empty spaces. The aim of comparing these two systems, Salutogenesis and psychoanalysis through a conceptual piece of art, is to show that the SOC, its components, as well as power of resistance, are in themselves controversial. SOC and resistance resources are not simply the positive ends of a continuum, at the other end of which is a poor SOC, lack of resources or poor health. Components of the SOC and resistance resources contain in themselves their opposition, tension, void and potential for falling apart. Stressors are, in fact, imminent not only to the reality outside oneself but also to the SOC itself. The positive tone and a certain dualism of Salutogenesis are in this way called into question.

Conclusion

Salutogenesis stresses the importance of stability, collecting experiences which lead to a strong SOC and strengthening of resistance resources. However, what if there is no stability, if those strengths are questionable, and the best that is left is a shell, a façade of an emotion, which is otherwise interpreted as a resistance resource?

In the master thesis, the central motive was also a lack, lack of the parental care in childhood. However, that lack wasn’t understood as congenital, innate; there was explored if some positive strengths (attitudes, replacements, etc.) succeeded to compensate a lack.

Art is a medium which deals exactly with what is dual, positive and negative; it does not try to negate this dichotomy, but it tries to overcome it and rise above it. It deals with «real», but at the same time it is itself the «real», it deconstructs and changes the generally accepted order. Art can be inspiration to accept this void, stressful experience, in the way of partially leaving the realms of the rationalism and the symbolic (of speech, which science is part of), and opening a space for different experiences. Its visual, perceptive aspect, aesthetics and ability to enchant, can awake unexpected experiences and emotions. It is a source of a new optimism, which can erase at the other side, behind the realisation of void, loss and passing.

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Salutogenesis and Migration

Ewa Iwanow

At the end of European Summer School in Sardinia in 2009, I decided that my thesis would be connected with Salutogenesis, which was a dominant topic of the course. The concept of salutogenesis was introduced by Antonovsky (1988) who concentrated on what creates health rather than what causes a disease. According to this conception, it is important to focus on the resources and opportunities in order to manage stressful life situations, which cannot be perceived as burdens. I was particularly interested in migrants' mental health and their coping skills in their host countries. Migration is a complex and dynamic phenomenon which brings about many changes, such as, physical, social, cultural, biological, and economic. There are a number of difficulties and challenges which are faced by migrants, for example, language barrier and exploitation, social isolation, lack of family and friends, and loss of status. Thus, migrants constitute a vulnerable group, who is exposed to more health risks than the rest of population (Chetail & Giacca, 2009).

Mental health is an essential part of the overall health. It is also shaped by many factors, for example, lack of social support, rapid social changes and poor working and living conditions. According to Antonovsky (1988), a sense of coherence influences a person's capacity to deal with life stressful situations and challenges. It consists of three components, such as, comprehensibility, manageability and meaningfulness. They reflect a person's perception of the world, managing the resources, and finding the meaning in the situation.

The purpose of the research was to analyse the relationship between sense of coherence and self-efficacy. The self-efficacy concept was developed by Bandura (1977) and it is connected with an individual's capacity to achieve their personal goals. In my studies, a total of 134 of Polish immigrants who were living in Galway at the time of the study were asked to complete a questionnaire consisting of 10 general questions, 29 questions of the Sense of Coherence scale, and 10 questions of the General Self-Efficacy scale. The validity of the Sense of Coherence questionnaire was confirmed (Eriksson & Lindstrom, 2005), as well as the validity of the General Self-Efficacy scale was justified (Luszczynska et al., 2005). The study was observational cross-sectional in design. The study was also designed to deliver quantitative data, therefore, it was analysed using SPSS statistical computer software. The majority of the participants in the sample were young, 56.7% were between 26-33 years of age, and single-36.6%.

The main problem in the host country identified by the participants was discrimination (44.8%). Other problems and difficulties included work below their qualifications (25.4%), sharing housing (20.1%), access to support services (17.2%), and language barrier (14.2%). In the study, the results revealed that Polish immigrants, who declared they were not discriminated at work, had higher prevalence of high sense of coherence (58.7%), than the participants who claimed that they were discriminated

at work (41.3%). With regard to self-efficacy, crosstabs demonstrated that main barriers in the host country had an impact on Polish immigrants' self-efficacy. An illustration can be low self-efficacy scores of the participants who declared their main problem is sharing housing, access to support services and language barrier. In addition, there was also a relationship between the sense of coherence and self-efficacy. High scores of the sense of coherence of the participants were also reflected in their high coping skills. Antonovsky (1988) claimed that an individual, who perceives a challenging situation as meaningful, manageable and comprehensible, mobilises their resources and is able to confront the situation. However, as the findings of the study clearly indicated, both the sense of coherence and self-efficacy were affected by the participants' new environment. Migrants were faced with many challenges including living and working environment, acculturative stress and lack of support. Some policy implications can be suggested regarding decent employment, as well as migrant support and advocacy services.

Group 'Sisters' Presentation, Islamic Mother & Child, Perugia, 2005

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Where My Roots Are?
"Healthy Roots – Powerful Tree!"

Viktorija Rehar

Introduction

This year, Slovenian Union for Health Promotion and Health Education is celebrating the 20th anniversary. Beside many innovative health promoting programmes and project, one is particularly based on my experiences as the ETC-PHHP participant on the Course in Prague 1997. During the course, we were learning and discussing the importance of genogram in our health promoting work. Therefore, immediately turning back home I introduced the idea to my colleagues and we started development and implementation of the project »Where my Roots Are? Healthy Roots – Powerful Tree".

The project

Searching the way how to introduce genogram, was very exciting, especially regarding the to a person itself and to various professionals and lays. This is a learning process of communication, supported by good knowledge of holistic human development, physical, psychosocial health, essential health needs. The message is how to cover the needs of individuals and solve the existing human problems.

The main goals are:

1. To understand and to be aware of individual action.
2. To learn each individual how to communicate with himself and others.
3. To obtain self-esteem and sustainable quality of life and environment.

To know hones roots means to know the person itself. Everybody could search inside oneself the reasons, reactions in solving problems and doing the activities, which can be not understand and explained. A look deep inside yourself, search to the explanations, solutions reasons, why we do some actions and reactions in a certain way.

So we, step by step, discover the way for better understanding of ourselves and of the others. This is an important part of sustainable quality of life.

Positive thinking model contributes to the useful approach of an individual and to the common problems, obstacles, stress and lack of the power. It is much connected of how an individual is able to manage oneself. He becomes aware of the importance of other factors like communication, building attitude, the conversation between people, values, responsibilities, a sense of partnership, mutual relations, lifestyle, health education, health promotion and healthy environment and practice.

Youngsters, by all citizens, healthy or ill, need all mentioned topics for personal growth and self-esteem of each individual starting very early in childhood and. Domestic and local communities are the focus of our interests.

The project was exposed and presented in health expositions to the public in 1994, 1997, 2005 and after at workshops, conferences for professionals from different national sectors, NGO's for the lays at local community level in Slovenia. Some examples are on photos.

The forest as a virtual model

In the nature and environment, more precisely in the forest are the answers and solutions of doubts, interpretations of the person's performance and expectations, where we can learn how to work and function positively in different situations as partners or in the group.

The idea

The idea of the project was found in the legality of the nature. In the forest the attentive observer notices the integration and harmonization of many partners like flora, fauna, trees, birds and human, act.

What is happening in the forest in reality? Slowly but surely each moment from the beginning until now, something has been changing. The changes are continuous and evident also today.

All partners in this process are included and live in some kind of symbiosis. They

need to be adaptable to the consequences and influences for centuries. The human is not excluded. We have to be aware of all the natural and environmental changes and the rise of new species.

Lifelong learning from example

We can all pay attention and learn from innovative practices. Our project priority is aimed to work in finding our roots. The human being – the person, has similar and parallel experiences of the recognized common changes as are valid in the forest.

The transformation has been done and gone during the process of development and evolution through many involuntary changes in the history and today. A person too has to follow the evolution. It is very helpful look for our roots. Such approach can give us a valid, clear explanation, who we are, what we are, our feelings, life…

To know the family, the relatives, predecessors from many generations lead's us to get a complete picture of own roots, own feasibility, deficiency, opportunity, weakness, in the habits too establish the realistic self consciousness. This individual is able to take responsibility for his decisions and consequences and solving every day distress and problems. Many questions are open and demand the proper answers.

Strong support of knowledge, practice, power and will to do something on your own, for one's health and environment. The promotion and the prevention of positive activities in public health at all levels and sectors in the society contribute to raise awareness.

Be positive in approach to yourself and to every body. Show the possible way how to over come the consequences, prevention's and promote the existence of non-communicable diseases, better psychosocial climate and overall progress in the whole society.

The roots are the basics of discovering and developing the background of our behaviour. The effectiveness is up to the common understanding and acceptance of matter and objectives that we faced during the lifetime.

So you can better understand yourself, also others. And you can live with other.

Where are your roots? Do you know your origin? We are learning from the nature and collecting the experiences. We are looking for our way. In which directions you would like to go in the woods, in life? Which tree in the forest are you? Are you the tree of life? Where to starts the quality of life and health promotion?

Sustainable lifelong learning starts in the cradle, at home and in the family. This warm and safe nest built the courage of the child, the confidence, self-esteem, to be happy and content lifelong.

So many things stimulate his potential's. Research the ancestor's root contribute to wide understanding of own reactions.

Now the human is able, will, do, to know itself, own needs, possibilities, weakness, difficulties, troubles, seeking and finding the solutions and also needs for playing and working, has hard fun and hard time.

He didn't forget to smile, to be kind for himself, to others, to those which are different from us, handicapped, ill …

A good knowledge with the big hearth, good book, innovative and creative thinking, ideas, those we love, family, friends, affects stimulations.

Quality care, hygiene, nutrition, sports, movements, walking, regular exercises strengthen healthy mind and body.

T**o obtain the common values we have used positive examples from the practice.**

Each day we must do something for ourselves. Ideas and actions all kinds of communications as listening, smiling, kind words confirms and enriches values of oneself and its sense of responsibility, help, respect, good will, leisure time are the most significant promoters for healthy life style.

Remember you can learn this.
Become successful also by the everyday activities.

Let's start

The trees in the forest are likely big, high, sensitive, some have stronger resistance. Every blow of the wind could, can hurt the sensitive ones. Some are stronger towards every kind of changes if we treat them all and take care of them. Trees with strong roots can't hurt not even disable every attack.

Let's look the great acer, strong pine, slim spruce, high fir, bright lime tree, nicely done acer and more others.

The same is with people. Very different is living together. Let's find the same point, which bring them near together, make them happy and the quality of lifestyle.

Where are you? Do you know how to go together? Like the creative team? Do we walking in the same direction? Some are chosen the opposite side, others before or after us. Exciting is to search original, innovative way. Confirm self-values!

Let them be free, invite them to join us and contribute to the progress of all kind and to the same goal. Then will trust us and learn how to go together and how to rich the communications. We believe and trust in their ability. Important is to support and understand each other, to rich to common code of understanding. It's nice growing, developing and changing together.

Changing yourself means to change the people in positive way, to provoke the change in the global world around us.

Building Bridges Between Health Professionals and Journalists

Ognjen Brborović, Tea Vukušić Rukavina

Since 2000 Media and Health Courses have become an integral part of the Motovun Summer School of Health Promotion and the focal point for yearly health and media professionals gathering. Annual Media and Health Course has been organized in collaboration with the Croatian Journalists' Association – Section of health care since 2002. Mission of the course is simple yet hard to achieve, to improve collaboration between media experts and health professionals.

Media and Health Course gathers all journalists' members of the Croatian Journal Association – Section of health care journalists, physicians, Ministry of Health officials, hospital managers, representatives of pharmaceutical companies, physicians and representatives of health related NGO's. Events like this, that give a chance to media experts and health professionals to work together and learn from each other, are very rare globally, but informal and charming surrounding of Central Istria is helping to keep usually confronted sides on the same goal of improving collaboration. That's why our course has throughout the years become almost unique, and each year we have "old" participants who are coming back to Istria to enjoy the spirit of understanding and tolerance, and each year we attract more and more new participants.

Each year main theme of the course (being held on the first day of the course) is defined according to current situation and events in Croatian healthcare policy and politics. Second day of the course is devoted to our primary goal, improvement of the collaboration between media experts and health professionals who are achieved through numerous team building exercises and activities. Health professionals also have the opportunity to learn new skills in public relations and how to present their messages to the media.

Media and Health 2001 Course convened large number of participants who arrived from almost all Southeast European countries (Albania, Bulgaria, Romania, Yugoslavia, Bosnia and Herzegovina, Croatia) to discuss the issues of democratization of society (improving access to information concerning health and environment and journalist ability to communicate them to general public), on how to bring improvements into the health and media experts relationship, on how to raise health issues on the editorial and policy agenda, on how to improve Ministries and media relationship and how to create an Internet-based health news exchange (in response to globalization, media and health issues).

Media and Health Course 2002 started exploring gaps in crisis communication among health care professionals, journalists and general public. Since the "Baxter case", October 2001, in which 23 patients on dialysis died due to manufacturer's mistake, health related crisis seemed to become Croatian everyday story. During that course

Relaxation after a hard working day, Bergen 2008

we have started to work on crisis communication plan which would obligate all interested parties.

Motovun and Health Course 2003 continued discussion regarding crisis communication, resulting with preliminary "Guidelines for crisis communication", developed by Croatian Journalist Association, Ministry of Health of the Republic of Croatia, Croatian Parliament, Croatian Health Insurance Fund, Croatian Chamber of Physicians. 2002 and 2003 Motovun Media and Health Courses emphasized the need of introducing the role of a spokesperson in Croatian health care sector, especially in national institutions like Ministry of Health, Croatian Institute of Public Health and large clinical hospitals.

In 2004 we devoted Media and Health Course to credibility of information and patient's rights, in 2005 to mistakes, both in medicine and in health journalism, and in 2006 during Media and Health Course new reform of Croatian health care along with Health Strategy of Croatian Ministry of Health was presented to public.

Since 2007 Media and Health Course is being held in Grožnjan, another beautiful Istrian small medieval town. Since we try to stay current with the issues every year, Media and Health Course in 2007 was called "Political battle for health" because Croatia was facing parliament elections in November 2007. We have invited all parliament parties from Croatia to present election programs concerning health and health care. By emphasizing health in our parties political programs we wanted to give our politicians an opportunity to present their visions of Croatian health care development, to see whether they are feasible for health care work force and acceptable for patients, are they restrictive or developmental.

In 2008 we devoted Media and Health Course to the public presentation of the new health care reform in Croatia, which started in June 2008 initiated by the newly elected Government and Ministry of Health. Our guest Mr. Stjepan Mesiæ, President of the Croatia, gave a lecture entitled "Public Health Issues – Role of Media and Physicians Responsibility", emphasizing the influence of media on public awareness about public health issues and responsibility of physicians' to become the active part in communicating the key messages to the public.

Media and Health Course 2009 was focused on healthcare reform in the era of global recession, providing the insights of key decision makers on possible effects of recession on healthcare budget.

Media and Health Course 2010 emphasized the problem of the corruption in Croatian healthcare and our key note lecturer was, then very new, President of the Croatia, Mr. Ivo Josipoviæ.

Media and Health Course 2011 was devoted to aspects of private and public healthcare. The decision makers of Croatian healthcare policy presented their visions of future development of private-public partnership.

Our experiences in the last 10 years working with Croatian Journal Association – Section of health care journalists confirm the thesis that communication is essential. Problems often occur when we only see one side of the problem (our side). Teamwork and networking provide better understanding, enabling media experts and health professionals to experience the demands of each profession.

Bad examples show us that there is much more to do in the domain of improving communication between media experts and health professionals, and we all have so much to learn. Good examples have become a part of the collective memory of Media and Health Courses and have silently become a part of our every day routine, as if they were always present in our communication. This is one of our successes, and the friendships made in Motovun/Grožnjan are very important success too. This is one of the ways we are trying to raise the awareness of t the importance and meaning of communication in health promotion, and to determine how by media present to public information that are relevant, evidence-based, ethically correct and credible.

25 Years of Capacity Building in Health Promotion in Germany

Eberhard Göpel, Arnd Hofmeister

Abstract

In this Poster we outline 25 years of capacity building in health promotion in Germany. Hereby we focus on the aspects training, research, and practice. Inspired by the Ottawa Charter postgraduate training programmes in the Public Health Sciences emerged in the early 1990s followed by undergraduate programmes. To coordinate training programmes in health sciences the University Network "Universities for health" was funded which includes today more than 23 universities. To establish Health Promotion as a specific scientific approach first attempts are made in 2010 to establish a research network in German speaking countries. Parallel to that academic development, inspired by WHO, several practice networks developed in the last 25 years. Starting the healthy city, other settings like workplace, school, university, childcare, hospitals, prisons, but also regions were established. Health Promotion is still a growing field of practice although its stable foundation in the health care system or in other public structures is still a task for the future.

Background

The focus on population or public health is not a genuine perspective for the German statutory health care (Bismarck) system with its over 250 sickness funds. Furthermore the public health services on the national and federal state level are rather weak. That is why health policymaking was for decades institutionally driven and not based on evidence. Therefore it needed strong international impulses to establish public health training programmes.

Training

The first Public Health Training Programme was established in 1990, the first Bachelor in 2002. Momentarily there are 20 Master Programmes in Public Health and Health Promotion and 11 Bachelor Programmes. Of these programmes 58% are taught in Universities of Applied Sciences, 25% at Pedagogical Universities and 17% at Universities (Hartmann et.al. 2010). Universities of Applied Sciences have rather a practical approach to academic training while universities focus more on research.

Since 2003 the Association Universities for Health was founded and counts momentarily 23 universities. This association works on the development a qualification framework

for public health and health promotion, organises conferences, designs innovative instructional approaches, provides e-learning material, and undertakes research.

Research

The oldest research association next to the German Society of Social Medicine is the German Society for Public health funded in 1997.

Research in Public Health and Health Promotion is still growing. There are several old journals on health care, but only recently (2006) a new scientific Journal for Health Promotion and Prevention was launched.

Research funding has been difficult for the area of public health, since its funding was part of medical sciences. But in 2009 there was a huge funding for sustainable research in prevention by the federal ministry of Research. This Network built six working groups: methods, policy transfer, practice transfer, social inequality, prevention and rehabilitation, and participatory health research.

In 2010 a German Speaking research Network for Health Promotion was launched.

Practice

The development of Practice Networks started in 1989 with the foundation of the healthy city network Germany. Since then regional, national and international networks have been established mostly around settings:

- Settings of the educational chain: child-care, school, university
- Settings in Health care: hospitals, nursery homes
- Workplaces
- Prisons
- Geographical settings: cities and regions

(Siebert, Hartmann 2007)

On a national level an expert forum “Alliance for Health promotion” was founded in 2000. This was transformed in a round table and finally resulted in the foundation of the „German Forum Prevention and Health Promotion“, in which most relevant organisations in that field are represented.

The professional association for health promoters was founded in 2004.

Summary

Generally the capacity building in health promotion in the last 25 years was very successful. Especial in the practice field a lot has been achieved. The research part is still to be developed further.

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Capacity Building in Public Health in South Eastern Europe (PH-SEE)

Ulrich Laaser, Luka Kovačić, Vesna Bjegović, Jadranka Božikov, Lijana Zaletel-Kragelj, Gordana Pavleković

Due to political changes in the last two decades of the 20th century the health care systems in countries of the South Eastern Europe became predominantly curatively orientated despite the tradition towards preventive medicine and public health in some of the countries, particularly in the former Yugoslav republics that are now independent statesl (Slovenia, Croatia, Bosnia and Herzegovina, Serbia, Montenegro and Kosovo). Political changes led not only to a dissolution of the former multinational state but also to a terrible and bloody war between them followed by political and social changes caused by transition from socialistic system to democracy and free market economy that happened also in other South East European countries formerly belonging to Warsaw pact (Bulgaria, Romania, Moldova). Public health became insufficient due to war as well as economic and political changes. The main problem was a lack of competence in public health above all in health management and strategy development, but also in the fields of health surveillance and prevention. Therefore, the project for the development of training modules and research capabilities in public health in South Eastern European countries (SEE) was proposed to the Stability Pact (PH-SEE Project). The co-operation between School of Public Health in Bielefeld and the schools of public health and public health institutes in South Eastern Europe including the countries Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Kosovo, Macedonia, Moldova, Montenegro, Romania, Serbia and Slovenia started officially in June 2000. The Athens School of Public Health was also involved in the co-operation. The schools of public health in Bielefeld and Zagreb took co-coordinative role.

The main objective of the project was to support the reconstruction of postgraduate public health training through development of teaching materials in English for the Internet. A regional network of lecturers in the health sciences was established. The up to date texts should be of international standard but also be of regional specificity. It was pointed out that to re-link the split-up professional training and research in the field of public health is an essential component of the program.

In order to sustain the co-operation in SEE countries after the Stability Pact Project will ended, an Agreement was signed by the schools and institutes of public health from SEE countries in September 2002 at the annual Assembly of ASPHER held in Zagreb. The Network changed the title to the Forum for Public Health in South Eastern Europe (FPH-SEE).

During the first two years the funding comes from the Stability Pact for South Eastern Europe through the German Academic Exchange Service (DAAD - *Deutsche*

Academische Austauschdienst) and covers exchange of lecturers in Public Health between Germany and SEE as well as within SEE, summer schools and conferences, and editorial work. The established network of schools and institutes of public health continued cooperation supported in some functions by DAAD through the MetaNET project and local resources.

The main results of the network were the Internet based teaching modules developed, tested and used mainly by authors from the region in the areas. This Curriculum is a result of mutual work of public health teachers from different training and research institutions, predominantly in South Eastern European countries, members of the PH-SEE Network. The main aim of this Curriculum is to support and improve the quality of postgraduate training in public health based on specific health and training needs in South Eastern European countries, using a Pan-European context.

The Curriculum consists of units, each comprising a number of related chapters. For each chapter several training modules of varying length will be available during a continuous development process. These modules should be used in postgraduate training program and/or continuing education for public health professionals.

Modules are prepared in such a way that each lecturer in the PH-SEE Network can use them in his/her own teaching practice. *Standard Forms* (short description of modules) are visible for all visitors. Full texts (accepted upon reviews) are accessible for authorized members only. The Internet Platform provides an opportunity for continuous development of the Curriculum contents. All teachers in the PH-SEE Network and those who are actively involved in different capacities in training and research in South Eastern Europe countries are welcome to contribute as authors.

Based on the Curriculum described above and available at *http://ph-see.snz.hr/curriculum* a series of books was planned to be published by the Publishing Company Hans Jacobs from Lage, Germany (Table 1).

The publication of the series has been supported by the German Academic Exchange Service (DAAD - *Deutsche Academische Austauschdienst*) with funds from the Stability Pact and later trough MetaNET Project, including Academic Programmes for Training and Research in Public Health in South Eastern Europe (FPH-SEE).

German National Library lists this publication in the *Deutsche Nationalbibliografie* with detailed bibliographic data available on the Internet at http://dnb.ddb.de.

All six volumes are available in PDF format for download at *http://www.snz.hr/ph-see/publications.htm* and in addition all six volumes are included in one CD widely distributed. In addition all modules included in volumes 4-5 are available within the open access Literature database of the University Bielefeld: *http://biecoll.ub.uni-bielefeld.de* and modules of volumes 6-7 will be added, too.

Six volumes published within six years between 2004 and 2010 encompassed altogether 247 modules, authored by 202 authors (503 authorships) coming from 18 countries and two international organizations (Table 2). Numerous conferences and meetings during a decade of cooperation resulted not only in 4360 printed pages of

six books but also in re-establishment of professional links between public health teachers and researchers from SEE countries and their contacts with colleagues throughout Europe and world-wide.

The activities were not limited to the Curriculum development and editing of the books but included organization of several summer and winter schools for young teaching staff, seminars and yearly coordinating meetings as well as the organization of student's conferences. One of very important activities was the exchange of teachers and students between Bielefeld, Zagreb and the Network members. As a result of the cooperation among Network members more than 50 papers were published in scientific and professional journals. The Network supported foundation of the new schools of public health.

This cooperative work may serve as an example for a brighter future in a war-torn region and the re-establishment of cooperation and peace building in the service to the health of people.

Table 1. A series of handbooks for teachers, researchers and health professionals has been published by Hans Jacobs Publishing Company as a result of collaboration within the Forum for Public Health in South Eastern Europe with subtitle Programmes for Training and Research in Public Health

1. Vesna Bjegović and Doncho Donev (eds). HEALTH SYSTEM AND THEIR EVIDENCE BASED DEVELOPMENT. Lage: Hans Jacobs; 2004.
2. Silvia Gabriela Scîntee and Adriana Galan (eds). PUBLIC HEALTH STRATEGIES: A TOOL FOR REGIONAL DEVELOPMENT. Lage: Hans Jacobs; 2005.
3. Lidia Georgieva and Genc Burazeri (eds). HEALTH DETERMINANTS IN THE SCOPE OF NEW PUBLIC HEALTH. Lage: Hans Jacobs; 2005.
4. Doncho Donev, Gordana Pavleković and Lijana Zaletel-Kragelj (eds). HEALTH PROMOTION AND DISEASE PREVENTION. Lage: Hans Jacobs; 2007.
5. Luka Kovačić and Lijana Zaletel-Kragelj (eds). MANAGEMENT IN HEALTH CARE PRACTICE. Lage: Hans Jacobs; 2008.
6. Lijana Zaletel-Kragelj and Jadranka Božikov (eds). METHODS AND TOOLS IN PUBLIC HEALTH. Lage: Hans Jacobs; 2010.

Volume 7 is now in preparation under the editorship of Professor Doncho Donev:

7. INTERNATIONAL PUBLIC HEALTH to be published by the year 2012.

Table 2. Altogether 202 authors coming mainly from South Eastern European countries but also from other countries and two international organizations authored 247 modules included in six volumes published between 2004 and 2010 comprising 4360 pages (in parentheses are number of authors coming from each country/organization)

1. Albania (2)
2. Bosnia and Herzegovina (4)
3. Bulgaria (22)
4. Canada (3)
5. Croatia (22)
6. European Commission (1)
7. Germany (14)
8. Hungary (2)
9. Macedonia (42)
10. Moldova (2)
11. Montenegro (1)
12. Netherlands (2)
13. Romania (12)
14. Serbia (22)
15. Slovenia (34)
16. Switzerland (1)
17. Turkey (1)
18. United Kingdom (7)
19. United States of America (3)
20. World Health Organization (3)

Local Drug Action on Korčula

Matija Čale Mratović, Ivana Pavić Mikolaučić, Karmen Kmetović Prkačin, Marija Mašanović, Asja Palinić Cvitanović

Introduction and identification of needs

Reports from 2003 pointed out a decreasing trend in drug abuse (marijuana and heroin) in western countries in Europe. In, Croatia, Dubrovnik Neretva County at the same time trend in drug abuse was stable, but number of heroin addicts increased on island of Korčula. The highest illegal drug consumption was in Vela Luka (around 100 heroin addicts out of 3549 inhabitants aged 14-65). Rates of adolescent drug use were at epidemic proportions. Research conducted by Public Health Institute in Dubrovnik Neretva County among school children discovered three times more heroin users in Blato and Vela Luka than in other parts of the county.

At the same time there were no special preventive programs as well as systematic follow up. Drug trafficking was blossoming and island itself was one of the main routes of drug entrance from other neighbouring counties. Mighty macro-dealer on the island, together with the great number of little sellers, made sure that drugs are in the flow constantly. In the other hand small number of special police officers was in situation like this incapable and inefficient. Parents in Vela Luka were alarmed in 2003. With greatness of the issue and without institutional help, they have found the first parental association in the County. The same year, County opened counselling centre for prevention and out hospital drug abuse treatment in Korčula and Blato.

Objectives: purposes of the work

Purpose of this work is to describe work and achievement of Local Drug Task Force that was set up by County Council on International Day against Drug Abuse 2003. Wanting to facilitate an effective response to drug problem on the island. The main goal of the project was to decrease number of young people who abuse (use) illegal drugs (predominantly marijuana and heroin). The objectives of the project were to raise the awareness of problem and the options for prevention and treatment, improve and increase the access to treatment, promote intersectoral collaboration, implement school prevention programmes, support families with drug problem and improve the efficiency of all institutions.

Description of what was done

For the intervention model, preventive approach based on community model was selected. It was selected after analysis of risk factors for problem genesis, problem

of sustainability and opportunities and resources in the community. Methods and processes included an action plan for two year period. Some of the methods used, were a team approach through periodically meetings and on-going training, local researches and follow ups, drug related training to the community, treatment facilities, outreach, and harm reduction. Leader institution of the project was Public Health Institute (PHI) of Dubrovnik Neretva County. Members of LDTF were representatives from state offices, health institutions (physician from PHI and family physician), schools (principal and expert staff), social welfare, police forces, local politicians and representatives of local government, people from media, and members of NGO-s. (15 permanent members, and 32 included for different tasks during project).

Special challenge for LDTF work was that it had to be active in three different, separate mid parliament (Korčula, Blato and Vela Luka). In every, problem was of different size, so was the sensitiveness and motivation for action also different.

LDTF held 7 meetings where situation analysis, goals and objectives, action plan, activities, results … were discussed. Each institution has made his plan, than coordinated with others. With modest financial assistance, all work was mainly incorporated into the regular labour assignments of all participants who put additional efforts and enthusiasm into realisation of the Project. In order to enhance team work, mutual understanding and knowledge in the field of drug abuse prevention, 2 educational trainings for members of LDTF were organized. Around 1800 of working hours were realised on total project activity for the whole island.

Project activities realised through 2004 and 2005:

- 2 new facilities and substitution program for heroin addicts (methadone, buprenorphine) have been established and still are successfully dealing with their work.
- Harm reduction program (Needle exchange program led bay NGO Help) and
- counselling centre for AIDS, with free access and free testing for AIDS, hepatitis B and C started in 2005.
- Same year NGO Life-Vita in collaboration with NGO New Life from Neighbourhood County started Outreach work with addicts.
- Number of education campaigns (professionals, community, children and parents) through media were held (20 broadcast); more than 210 lectures and workshop for children in primary and secondary school, 16 for parents held, public discussions, number of controls selling an alcoholic beverages to younger than 18, two questionnaire, exhibitions ….
- Document „Minimum issue for the realization of School Preventive Programmes" has been created, defining subject and content for students and parents (in primary and secondary school).

Discussion of what was achieved and how the work has advanced our understanding of the topic

Based on qualitative and quantitative data collection, results of the project were available. Performances of all local institutions included have been improved in quantity and quality. Number of addicts included in the treatment increased significantly, from 20 heroin addicts in 2003 to 65 in 2005. Youth participating in the focus groups (in 2005.) indicated "peer group attitudes". According to their answers, easy availability of drugs in the neighbourhood and opportunities for drug use are still high, but peer group attitudes, norms, and behaviours regarding drug use have changed. Drug is available, but not acceptable as before. Research on drugs consumption among students in secondary school in Dubrovnik Neretva County led by County PHI in the April 2006, indicate decrease of heroin consumption on the island Korcula, especially in Vela Luka (place with biggest problem with drugs consumption). In 2006 in Vela Luka heroin experienced at least ones only 2,2% of students comparing with 10,8% in 2001, and 9,8% in 2003.

In the same time average time of regular use of drugs before coming to treatment facilities has been decreased, although the time of first use of drug is the same (first taking drugs at age 15, first taking of main drug at age of 19 and first intravenous taking at age 21). Average time of regular use of drugs before coming to treatment is 7 years in 2004, 6 years in 2005, and 5 years in 2006. Comparing to other parts of Croatia and Dubrovnik Neretva County drug addicts on Korčula 2,6 times more often come to treatment on suasion of family.

Efficiency of this project was also evaluated with evaluation questionnaire by members of LDTF (people from PHI were excluded). From 25 forwarded, 15 are returned. Evaluation questionnaire valued next: conviction about possibility of making changes, time spent in project, personal contribution to the activity in project, communication and cooperation, assessment of promotion of efficiency for the whole system on island Korčula, readiness for further participation, obstacles and challenges, missed opportunities, suggestion for the future and satisfaction with project. The questionnaire valued response on the scale from very much, much, medium, little, not at all (in numbers from 5 to 1).

Communication between participants was rated with average grade 3,25. 94% of participants consider that working together improved communication. Considering period before project started they rate improvement with grade 3,1. Highlighted were commoner and better cooperation between schools, Social service centres, police and health departments. All participants believe that participation in project improved their own efficiency. That improvement was rated with rate 3,25. Working together also helped them to comprehend their role better, clarify expectation and boundaries towards others (average grade 3,5). The lowest grade (2,7) was for improvement of effectiveness for whole system on island Korčula, general satisfaction with project (2,8), while greatest grade got usefulness and need for working together in this way (4,3).

All participants answered that they believed it was possible to make a change, but time and all subjects in corporate coordinated work are needed.

Conclusions: take-home messages

General conclusion is that the island Korčula should not be observed as a unified whole. There is great difference between the individual units of local government in the accession problems as well as the capacity to practice with addiction. The problem of coordination and management is a challenging and it should maintain intensity and quality of work. Education of all participants in the project, as well as teachers, professors and principals who are responsible for the implementation of the school prevention program should be priority. Coordination of the programme should exist in every local community with a help and supervision of experts from outside. It is possible to make a difference. Critical factors for success are collaboration, effective training and education for the public and all sectors included treatment access, but a key role has a highly motivated people from the local community and NGO-s, recognition of the problem and involvement of the local people and local media.

Part 5
Capacity Building in European Union and Abroad

Trouble in the Homeland of the Ottawa Charter? The Professionalization of Health Promotion in Canada

Michel O'Neill, Brian Hyndman

Introduction and objectives

The fact that the Kyoto protocol was signed in Japan does not this automatically make this country a global leader on climate change control. Similarly, it is not because the Ottawa Charter for Health Promotion (WHO, 1986) was proclaimed in Canada that this country is a *de facto* leader in the field, even if it is still perceived internationally as such more than 20 years after the proclamation of this historical document (O'Neill and al., 2007). In this paper we argue that, surprisingly for many foreigners, the professionalization of health promotion in Canada is not very advanced, we propose a few reasons why it is so, we discuss the pros and cons of this situation and finally, we look at what might be the future of the phenomenon. Our argument is based on several decades of critical analysis of the field by one of us (O'Neill and al., 2007) and on key developmental work in health promotion competencies in Canada and internationally by the other (Hyndman, 2009); it has been developed in a more detailed paper (Hyndman and O'Neill, 2011) from which it borrows its key arguments.

The situation

A few contextual elements

First, it is important to remember that Canada is an enormous and very sparsely populated country of 34 million people, the immense majority being concentrated in the southern part of its territory along the US border. Politically speaking, Canada is a federation of 10 provinces and 3 territories and the respective powers of the Federal and the Provincial and Territorial governments were originally defined in 1867 in a British law that acted as the constitution of the country up to 1982, when it became a Canadian law. It is thus important to understand that constitutionally, even if the federal government has significantly intervened since the second world war through its financial «right to spend», health care is essentially a provincial matters.

The period between the 1974 publication *A New Perspective on the Health of Canadians* (aka the Lalonde report) and the 1986 release of the *Ottawa Charter for Health Promotion* fostered the expansion of health promotion, both as distinct field of practice within the broader public health sector and as a viable career option. The nascent field began to take on the attributes of a health profession. The means by which a group achieves the status of a recognized profession has been a topic of study by sociologists for decades and is usually characterized by: 1) the development

of a specific body of knowledge; 2) the fact it is practiced as a full-time occupation; 3) the establishment of university degree programs teaching it; 4) the formation of associations to promote the profession interests, ensure quality control, establish a code of ethics and protect the public from dangerous practices; 5) formal legislation to regulate the profession if public safety and the broader public good are paramount.

As we will see presently, these contextual elements are key to understand the evolution of health promotion in Canada and of its professionalization.

Health promotion training

From 1979 on, post-secondary degree programs in health promotion have been developed across the country, either as disciplinary programs in themselves or, more frequently, as specialized concentrations in Masters in public health programs. Courses in health promotion also began to be offered in the basic training of health professionals such as nurses, or physicians. With respect to health promotion's development as a profession, we are of the opinion that conditions for this are currently not optimal at this time, given the insertion of health promotion into broader public health degrees rather than development of specific health promotion degrees.

Health promotion associations

Sporadic attempts have been made to establish a Canada-wide health promotion association since the release of the *Ottawa Charter* in 1986. In the late 1980s, efforts were made to expand the scope of the Canadian Health Education Society into a health promotion association, with interested members coming primarily from graduates of Ontario and Atlantic university programs in health promotion. However, CHES proved to be unsustainable and dissolved by 1991. More recently, the release of Canadian health promotion competencies has sparked interest in the development of a Pan-Canadian Health Promotion Network. Health promoters in Ontario, Manitoba and Nova Scotia have engaged in informal discussions about the establishment of such a network since 2008. It was envisioned that the Network would initially serve as a national advisory body overseeing the completion and adoption of a Pan-Canadian set of health promotion competencies. However, the Public Health Agency of Canada's elimination of financial support for profession-specific competency development has slowed the development of the Network, although discussions are still ongoing.

There has been a similar lack of progress in the development of health promotion associations at the provincial and territorial levels. The lack of progress may be a function of the limited number of health promotion practitioners within the broader public health sector (especially in smaller Canadian provinces) as well as the role played by provincial public health associations in hosting and supporting networking opportunities for health promoters. A notable exception exists in the province of Ontario, where Health Promotion Ontario (HPO) has served as the primary association of health promoters since 1987.

Health promotion competencies

Competencies guide the development of professional standards and systems of quality assurance. Since the 1970s, competency models have been increasingly used to clarify specific practice requirements for public health disciplines, including the practice of health promotion. (Battel-Kirk et al., 2009).

In the spring of 2006, Health Promotion Ontario was funded by the Public Health Agency of Canada (PHAC) to develop a set of Pan-Canadian health promotion competencies. A competencies list was thus released by HPO in 2009, after an extensive international as well as Canadian consultation process, which coincided with the release of the international Galway Consensus Conference Statement on core competencies for health promotion and health education. To date, application of the Pan-Canadian health promotion competencies has been limited, largely due to PHAC's withdrawal of funding for the profession-specific competency work in 2008, and the resulting lack of resources to undertake the consultations needed to transform a 'proposed' set of competencies into a final product with Pan-Canadian endorsement.

The development of health promotion competencies gave rise to debate about the merits of further steps towards the "professionalization" of health promotion. To date, the health promotion field in Canada has taken a cautious stance on this issue. A 2006 discussion document concluded that the development of formal accreditation mechanisms for health promotion would be rigorous, time consuming and potentially divisive due to concerns that had surfaced among health promotion practitioners whenever the issue was broached. In acknowledgement of this viewpoint, the proposed Canadian competencies are not intended to serve as an intermediary step towards mandatory accreditation processes to control the access into the health promotion field; rather they are meant to inform and stimulate dialogue towards agreement on a requisite skill set for health promotion practice in Canada that could be used to design academic programs or develop job descriptions.

Health promotion as a regulated profession

The ultimate step along a gradient of 'professionalization' would be the designation of health promotion as a regulated profession. In Canada, regulated professions are those regulated under provincial or territorial *Health Professions Acts*, legislation established to protect the public's right to safe, effective and ethical health care. Professional 'Colleges' are the regulating bodies established to ensure the accountability, performance, quality and transparency of regulated health professionals. Most, but not all, regulations include controlled acts that, if performed by a non-regulated individual, could engender harm and thus could become the object of a law suit for unlawful exercise of the profession.

It is our opinion that the prospect of health promotion becoming a regulated profession in any Canadian jurisdiction is highly unlikely because such a process could elicit competing demands for similar status by public health practitioners in other areas of the field (e.g., epidemiologists, public health inspectors) or for the recognition of

a generic public health profession. Moreover, the regulation of health promotion practice would probably fail to engender the support of a large segment of the health promotion field, which would view such a move as antithetical to health promotion's core values of participation, empowerment and intersectoral collaboration. It could also alienate other already existing regulated professions (e.g., nursing, nutrition, medicine or social work), which are currently providing health promotion services, potentially generating energy-draining "turf wars."

Conclusion

The disadvantages of a becoming a regulated profession thus seem more considerable that the potential benefits. A more likely, and probably more desirable, scenario is the emergence of a voluntary accreditation program. Kinesiology and evaluation are two examples of unregulated professions with voluntary accreditation programs currently existing in Canada, which might serve as models for health promotion.

The chief advantage is that it would provide practitioners with an opportunity to exercise greater control over defining the scope of health promotion practice, as opposed to having it defined for them by external funders whose interests may not be compatible with core health promotion values. It would also provide employers and academic programs with clear criteria for the training and recruiting of health promotion practitioners. Finally, this approach could finally help to reach a consensus on what health promotion is for Canada because by its very nature, it is not as neatly defined as more narrowly-focused disciplines.

A barrier to accreditation is that it is associated with considerable costs, including application fees that may serve as a deterrent to lower-income practitioners. This is an important consideration for a field that has long embraced equity and social justice as core values. The degree of emphasis an accreditation mechanism would place on different dimensions of health promotion practice (e.g., policy development vs. community mobilization) could also be a concern. Would equal weight be given to all domains of health promotion practice? Would it offer sufficient flexibility to allow for sub-specialization within a recognized competency area? These are but a few of the issues warranting careful consideration before any decisions about the adoption of an accreditation system are made but it nevertheless seems to us the direction to move towards at this point in time.

So, whatever the characteristic of a profession we look at, there is trouble in the homeland of the Ottawa Charter and there are even potential advantages and drawbacks to the adoption of the voluntary accreditation mechanism we advocate for by Canadian health promoters.

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Capacity Building in Public Health and Health Promotion in Croatia

Selma Šogorić, Gordana Pavleković, Aleksandar Džakula

Contextual framework

In the past years and even today, the term Health Promotion has have a variety of meaning in Croatia as well as in South Eastern part of Europe. One of the main causes for this uncoordinated terminology is related to historical development of Social Medicine, Public Health, Health Education and Health Promotion, particularly in this part of Europe.

Public Health (very often translated from English to our maternal tongue as a public health care) rose from the past hygiene, preventive and social medicine disciplines with a strong emphasis on the state responsibility for the care of population/nations health, mainly in the hands of health care sector and medical professionals. During the political, social and economic transitions, the term "New Public Health" was becoming increasingly used by a new wave of public health activists who were dissatisfied with the rather traditional and top-down approaches of "health education" and "disease prevention". Many of our professionals are still accepting Health Promotion as a tool within Public Health aiming to facilitate changes.

Example 1: Postgraduate study in Public Health

Appropriate education for people and health providers has always been the key issue in the mission of the Andrija Štampar School of Public Health. Since the beginnings in 1927, health professionals have recognized the School as the leading institution in postgraduate and continuous education for health. Considering its postgraduate activities, the School was a unique institution in Croatia, in the former Yugoslavia, in the South-Eastern part of Europe and in developing countries. It has been said several times that the Andrija Štampar School of Public Health continually keeps in the front rows. Today, the School has the main responsibility for training in Croatia in the field of public health, epidemiology, preventive medicine, occupational, school and family medicine. The learning objectives in all those master programmes are (a) oriented to particular conditions and priority health issues in Croatia and abroad, (b) related to the Health for All policy and Health21, stressing ethical issues, human rights and professional values, (c) evidence based in terms of the best available knowledge, (d) relevant to postgraduate training, multiprofessional and intersectoral education and teamwork, and (e) learning how to learn and how to continue learning.

The first Master program at School of Public Health was organized in 1948 as a common curriculum for master program in epidemiology and public health for the

first semester and specific for the second one. During eighties, the Public Health course had three streams: public health, health economics and health management. Based on the changes in terminology, master program was organized under the title Social Medicine and Organization of Health Services. After 1990, Master program has a title Public Health.

The aim of the program is to acquire knowledge and skills in the field of public health, and especially to train the candidates for assessment of health situation in the community, detection and assessment of social and economic factors influencing health of the population, planning, implementation and evaluation of health care measures, health education, planning and working with the personnel, application of general epidemiological, ecological, economic and social methods and measures, and other issues of public health.

At present, the postgraduate study in Public Health is part of the vocational (medical specialists) training in public health but it is (one of the few at Zagreb Medical School) opened to the students with other backgrounds as dentistry, nursing, pharmacy, low, social work, economy, management, psychology, education, rehabilitation, etc.

As it is written in nationally accepted accreditation, after completing the MPH program in Public Health, student should be able to demonstrate understanding of the three main public health specialist areas - health promotion, disease prevention and health care system organization and quality management.

In summary, after postgraduate training programme, students should acquire following knowledge and skills in:

Collection, analysis and interpretation of community health indicators, comparison with those of other populations, assessment and analysis of the health needs, planning for health skills and implementation of the public health interventions, literature search and the use of public health, on-line data bases (Croatia and WHO), critical assessment of the evidence of the effectiveness of the health promotion interventions, programs or services, analysis of the macro-environment with the aim to identify key stakeholders and their interrelationship, selection of the public health priorities (among recognized needs) with argumentation, analysis of determinants (problem root causes) and opportunities for intervention, strategy development for addressing priority issues, plan development and implementation (resources, actors, processes, monitoring and evaluation), information gathering from public health data basis (CDC, Cochran, USA, Canada and UK preventive medicine task force) about successful public health interventions, analysis of the effectiveness of fiscal, financial, legal and other measures aiming to improve health or prevent disease, use of information technology, statistical and epidemiological methods, cost-benefit analysis, collection and analysis of the health care system data, planning, organization, monitoring and evaluation of the health care system, personal management skills – recognizing own management styles and preferences (roles) in different teams, time management, people and resources management, project management (within available time and resources), communicational skills (written and oral communication, public and media relations).

At the first semester of the Postgraduate study in Public Health students are expected to take seven mandatory courses of the Common Core Curriculum (18 ECTS) and three to four electives that will bring them additional 8 ECTS. During the Second semester students will take five Specific Core Curriculum Courses (17 ECTS) and five to six electives (i.e. in amount of 10 ECTS). The Postgraduate study in Public Health ends with the public presentation of student's Master Thesis. Before applying for the thesis student are expected to pass all individual courses exams. Successfully written and defended Master Thesis will bring to student additional 12 ECTS.

In today's transitional Croatia public health specialists are becoming very valued and important especially due to the processes of decentralization and privatization of the health and the social welfare services. Local, regional and national health administration, health and social welfare services and profit (pharmaceutical), non-profit and voluntary sectors are demanding professionals with public health vocation.

Example 2: Capacity Building in "Health – Plan for it!"

Due to the war and post-war transition, Croatian cities are faced with many problems, like, for example, mental health, posttraumatic disorders, quality of life of disabled, family health, community regeneration and community capacity building, unemployment, especially among young and mid career workers, stress, alcohol, tobacco and substance misuse, etc. Key players able to bring changes in public health policy development and implementation at the county level were identified: as those who can (have political power), as those who know (have knowledge and skills) and those who care (have direct interest in bringing change). Political power at the County level in Croatia is within County Councils and their executive bodies County Departments for Health, Labour and Social Welfare. Technical expertise is within County Institute of Public Health and Centres for Social Welfare. Citizens groups and associations were seen as the most direct representatives of citizen's interest. The assumption was that only active participation of all mentioned key players from the political, executive, technical, and community arenas could improve process of creation and implementation of the county's health policy and guarantee better health outcomes.

But due to the centralized state policy and vertical process of decision-making used in the previous years, collaboration among the various players mentioned above has not been established. Non-existence of an articulated County health policy was a logical consequence of the lack of collaboration. County officials had insufficient knowledge of new population health needs resulting from the war, post-war transition and economic and social difficulties, and these needs have not been addressed properly. Consequently, the population is receiving traditional services, hardly those that respond to real needs. Throughout 90s County Councils did not have real political power and County Governors acted more as Central Government than County Government servants. With the exemption of the few old and well-equipped Institutes of Public Health majority of them was established within the last fifteen years. Through the collection of data, monitoring and reporting they provided primary,

information to national Institute of Public Health and did not see themselves as the players at the county level.

The first step in development of public health policy and plans at the local level in Croatia was assessment of present state and conditions. In the summer of 1999, directors of the Motovun Summer School of Health Promotion convened a panel of 25 Croatian public health experts to review existing public health policy and practice at the county level. The group used an assessment tool called the Local Public Health Practice Performance Measures Instrument, which was developed by the U.S. Centres for Disease Control and Prevention Public Health Practice Program Office This instrument recognizes three core functions of public health: assessment, policy development and assurance, and 10 practices associated with them. Three of the 10 practices emphasize important components of the assessment function: assessing community health needs, performing epidemiological investigations, and analysing the determinants of health needs. Another three practices address the policy development function: building constituencies, setting priorities, and developing comprehensive plans and policies. Finally, four practices relate to major aspects of the assurance function: managing resources, implementing or assuring programs to address priority health needs, providing evaluation and quality assurance, and educating or informing the public. The 10 practices mentioned can be used as performance standards, supported by the 29 associated indicators to measure the effectiveness of local public health practices.

At the same time, it was obvious that counties require professional public health guidance and assistance to develop more effective and efficient local public health practices, i.e., to assess population health needs in a participatory manner, plan for the health of the population, and assure the provision of the right kind and quality of services based on the population's needs.

Given this scenario in mid-2001, the process of change caused by decentralization was seen as an excellent opportunity for improving Public Health practices in Croatia at the County level and a »learning-by-doing« training approach appeared to be the best tool for public health capacity building and strengthening of collaboration between health policy stakeholders at the county level in order to both build knowledge and skills. Based on Healthy Plan-it™ program (developed by Centres for Disease Control and Prevention, USA) and building »Health – Plan for it« program proposal for Croatia, this programme aims to provide guidance and assistance to counties, while introducing more effective and efficient public health policies and practice. By the end of 2001, the program was discussed with several panels: public health physicians from County and National Institute of Public Health, county officials, health managers, Ministry of Health and Ministry of Labour and Social Welfare officials. Finally, it was revised and sent for comments to the pilot group of counties.

After two months of consultation the main program stakeholders reached consensus about the aims and content of the program. County teams will first complete four months of intensive training, which will be followed by biannual monitoring

and evaluation meetings. Since mutual learning and exchange of experience is an important part of the process, three counties from different parts of Croatia with different levels of local-governance experience will be in training at a time. Each County team should be composed of 9 to 10 representatives: three from the political and executive component (County Council and Department for Health, Labour and Social Welfare), three from the technical component (County Institute of Public Health departments, Centre for Social Welfare); and three from the community (NGO's, voluntary organizations and media). The Ministries will support the direct cost of training (training packet development, teaching and staff expenses) and the counties will cover lodging and travel expenses.

From 2002 till 2009, all county teams or more than 200 participants had completed the Healthy Counties program and produced County Health Profiles and County Health Plans with prioritized health needs and specific recommendations for addressing them. Since the City of Zagreb, as the largest city in Croatia, has County authority it completed a slightly modified program alone with 24 participants.

The pure existence of eighteen Counties (and the City of Zagreb) Health Profiles and Plans is the evidence that this program had built counties capacity to assess public health needs in a participatory manner, to plan for health and assure provision of the type and quality of services better tailored to local health needs. The Healthy Counties project has successfully engaged stakeholders from political, executive, and technical arena. It involved numerous and various community groups (youth, elderly, unemployed, farmers, islanders, urban families, etc.), hundreds of local politicians, and institutions in the needs assessment, prioritizing and planning for health cycle. The last but not the least: County Health Plans are accepted politically, professionally and publicly.

Example 3: Motovun Summer School of Health Promotion

(Organized by Croatian Healthy City Network and Andrija Štampar School of Public Health - School of Medicine, University of Zagreb)

The Motovun Summer School of Health Promotion was launched in 1994 as meeting point for people working in health promotion locally, nationally and internationally. The aim of this initiative is to link the academic community and centres of excellence with practitioners, people working in the field, and to enable them to exchange their skills, knowledge, experiences and ideas, respecting the values of the input that both sides are bringing into that process.

The School is open to various types of events, such as productive (creation of new values) and reproductive (transmission of knowledge) seminars and courses, conferences, ad hoc meetings (expert groups), workshops (acquisition of new skills), field visits, festivals or other interactive events with the local community. Health promotion and communication are the bonds connecting all the various topics and events. The topics change yearly and include the major issues of concern in the field of health promotion. The aim of the Motovun Summer School of Health Promotion

is to develop over the years into the training and communication centre for health promotion movement. In its development, the emphasis is put on the international character, mixture of disciplines and high quality work.

Examples: Titles of main course and workshops

Health Care Systems and Health Care Policy: Health in All Policies
Media and Health
Democracy Schools – Youth Parliament
Healthy Aging: Quality of Life
Health Promotion at Workplace
Risk Management and Risk Communication in Environmental and Public Health
Re-orientation of Health Care Systems
Mental Health and Well-being

It is not by chance that Motovun is the host of this School: Motovun is one of the best preserved Istrian hill walled medieval towns. Its walls were built in 13th and 14th century and are still well preserved. Therefore, Motovun is the best "healthy learning environment" as beautiful natural and historical resort because this Health Promotion School is also the School of Hope. This is the place for people who feel able to act and take actions in improving health and the quality of life of themselves, who do respect human rights and could demonstrate that there is, still, a room for hope in the present day Europe.

Part 6

Experiences in Capacity Building in Different National and International Framework

The CompHP Project

Developing Core Competencies, Professional Standards and Accreditation for Health Promotion in Europe

Barbara Battel-Kirk

The CompHP project aims to develop consensus on core competencies, professional standards and an accreditation system for health promotion practice, education and training that will positively impact on workforce capacity to deliver public health improvement in Europe. Funded by the European Agency for Health and Consumers, the CompHP Project is lead by Professor Margaret Barry of the Health Promotion Research Centre, National University of Ireland Galway. The project commenced in September 2010 and will run until August 2012.

The objectives of the project are:

- To identify, agree and publish core competencies for health promotion practice, education and training in Europe.
- To develop and publish competency-based professional standards for health promotion practice.
- To promote quality assurance through the development of a Europe-wide accreditation system.
- To map competencies and standards in academic courses across Europe and link to accreditation for academic settings.
- To pilot competencies, standards and accreditation with practitioners in a range of settings across Europe.
- To engage in consultation with key stakeholders and disseminate information on the project outcomes throughout the 27 member states and all candidate countries.

Drivers for the development of the CompHP Project included:

- Quality assurance issues for practice, education and training identified within all health fields
- Freedom of employment policies highlighting the need for agreed standards to facilitate employment across the EU,
- The workforce capacity required for promoting health as identified in European Union (EU) health strategies.

The work of the CompHP Project creates a new dimension in European health promotion by establishing the means and methods by which agreed core competencies and quality standards can be implemented across Europe to stimulate innovation and best practice. The development of a Europe-wide system of competency-based

standards in health promotion will provide a basis for building a competent and effective health promotion workforce capable of putting into action the key priorities identified in recent European health strategies. The project takes a consensus building approach and aims to work in collaboration with health promotion practitioners, policymakers and education providers across Europe.

Planned outcomes for the CompHP Project include:

- A shared understanding of, and consensus on, the core competencies required for health promotion practice, education and training in Europe.
- Competency-based standards that will inform capacity building for professional practice in health promotion across Europe.
- A template for a pan-European accreditation system to accredit individuals and education and training providers using agreed criteria.
- Enhanced education and training programmes in health promotion across Europe based on a shared understanding of the core competencies and standards that need to be incorporated into academic core curricula.
- The promotion of workforce development and best practice in health promotion through engaging practitioners and professional bodies in the development of quality standards and accreditation systems.
- Greater cooperation and coordination in health promotion practice, education and training across Europe, promoted by an active project consultation and dissemination process, leading to improved quality of practice based on agreed competencies and standards

The project uses a variety of participatory methods to build consensus including;

- Delphi surveys
- Online questionnaires
- Focus groups and workshops
- Online consultation using discussion forums and social media such as Twitter and Facebook

There are 24 CompHP project partners, of whom 11 are actively involved in the project workpackages while the remaining 13 contribute to the project as collaborating partners. The project partners represent a wide geographic spread Europe reflect the diversity of health systems and levels of development of health promotion in the region.

The CompHP Partners are:

Workpackage leaders

- Health Promotion Research Centre, National University of Ireland Galway (NUIG) which is the Coordinating Centre for the project
- International Union for Health Promotion and Education (IUHPE)

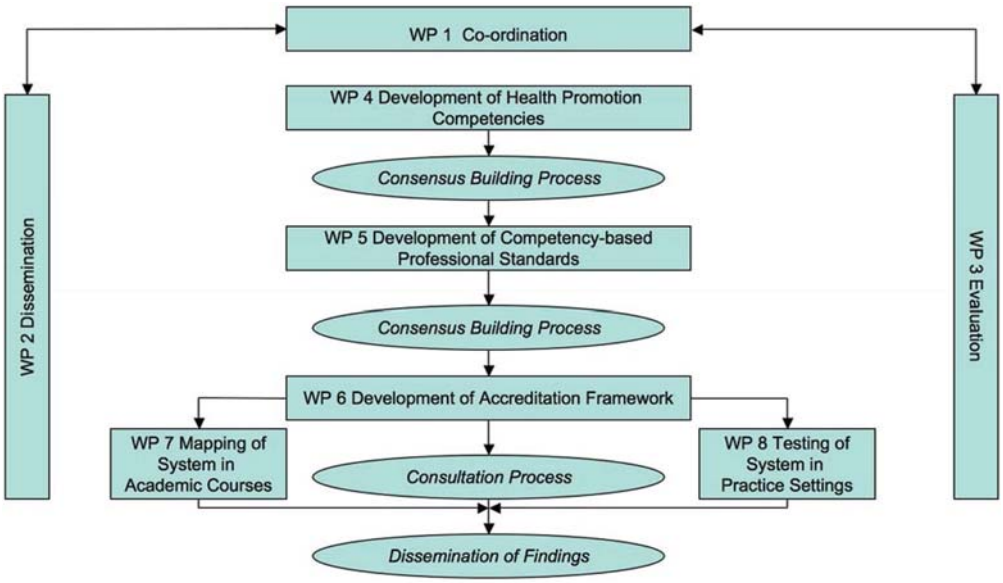
- University of Perugia, Italy
- Royal Society for Public Health, United Kingdom
- The Netherlands Institute for Health Promotion, The Netherlands
- University of Cagliari, Italy
- University Rey Juan Carlos, Spain

Partners

- Czech Republic National Institute for Public Health
- Estonia University of Tartu,
- Finland The Finnish Centre for Health Promotion
- Ireland Health Service Executive (HSE) Ireland

The project builds on European and international developments in developing health promotion competencies, standards and accreditation (1,2) and on research on health promotion practice and training in Europe (3) and a scoping study on the feasibility of implementing a Pan European Accreditation system for health promotion (4) .

Figure 1 Structure of the CompHP Project



The project is structured into eight units of work called 'workpackages'.Three core workpackages, which run for the whole three years of the project, focus on the coordination and management (Workpackage 1) the dissemination (Workpackage 2) and evaluation (Workpackage 3). The remaining workpackages focus on specific aspects of developing and testing the core competencies, professional standards and accreditation framework.

Progress

The CompHP Project reached its half way point in March 2011 and is on target to meet its aims and objectives. The first year and a half of the project has been very productive with two major publications completed, including the CompHP Core Competencies Framework for Health Promotion Handbook and a comprehensive review of the international literature on core competencies (5,6). In 2011 the focus is on the development process for two other handbooks - on Professional Standards and a pan-European Accreditation Framework for Health Promotion - both of which will be published in 2012. A survey on the first drafts of these is currently underway with over 200 stakeholders in the health promotion community in Europe, together with testing in academic and practice settings. Focus Groups, workshops and online consultation will also provide opportunities for feedback on these documents.

As well as producing the Handbooks, the process aspects of the project, and in particular on the lessons learned at each stage of progress, will be shared in a series of project reports, the first of which will shortly be available on the project website.

Further information on the CompHP Project is available on the project website: http://www.iuhpe.org/index.html?page=614&lang=en

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IUHPE Scoping Study on HP Workforce Capacity

Education and Training Needs in Low and Middle Income Countries (2010)

Barbara Battel-Kirk, Margaret Barry

Aim

The scoping study aimed to identify current capacity for Health Promotion and the priority education and training needs for capacity development in low and middle income countries globally.

Objectives

- To explore the terms most commonly used for Health Promotion activities
- To investigate current capacity for Health Promotion in relation to existing policies, posts and funding
- To examine the range of Health Promotion strategies employed and opinions on their appropriateness for best practice
- To assess opinions on the need for a dedicated Health Promotion workforce with specialised training
- To investigate existing education and training for Health Promotion and opinions on the adequacy of this to build and maintain capacity for Health Promotion
- To ascertain opinions on the relevance and cultural appropriateness of existing education and training
- To identify the main drivers for, and barriers to, education and training in Health Promotion
- To ascertain the availability of competency frameworks for health promotion and opinions on the importance of accreditation for Health Promotion
- To identify priority education and training needs
- To gather opinions on access to information on Health Promotion by those undertaking Health Promotion activities
- To assess opinions on existing strategies and assets in relation to capacity building for Health Promotion
- To investigate perceptions of the roles of regional and global networks for capacity building in Health Promotion

'Reach for the Sky', Project Poster, Perugia 2005

Context and Rationale

Supporting capacity building and training of the Health Promotion workforce is a central to building the infrastructure required for promoting health at the population level. Supporting the capacity building, education and training of individuals, organisations and countries to undertake health promotion activities is identified as a main goal in the workplan of the IUHPE Vice President for Capacity Building Education and Training and this scoping study was undertaken to inform the processes required to meet this goal.

In the field of health, capacity has been defined as:

> *'Capacity of a health professional, a team, an organisation or a health system is an ability to perform the defined functions effectively, efficiently and sustainably and so that the functions contribute to the mission, policies and strategic objectives of the team, organisation and the health system.' (1)*

Over the past two decades there has been a move away from the traditional concept of 'capacity building' focusing on technical training, to a more developmental approach reflected in the increasing use of the term 'capacity development'. An informed and strategic approach to the development of the Health Promotion workforce as a major element of capacity development is well established. There has also been a shift in exclusively focusing on the needs and development of the individual worker to including the organisational and strategic context as key to achieving sustainable workforce development. The scoping study built on a number of models and frameworks which reflect the infrastructural and strategic issues impacting on capacity and workforce development in health promotion, (for example, WHO 2010 (2).

Methods

Sample

The sample identified for the study comprised all countries defined by the World Bank as having low, lower middle or upper middle levels of economic income (145 countries) and these were grouped into the regions as defined by the IUHPE.

In collaboration with the IUHPE Global Board members, contact details were initially

Figure 1 Map of WHO and IUHPE region

WHO	African Region	Region of the Americas	South Eastern Asia Region	European Region	Eastern Mediterranean Region	Western Pacific Region
IUHPE	AFRO	ORLA (Latin America) NARO (North America	SEARB	EURO	EMRO	South West Pacific (SWP) Nothern Part of the Western (NPWP)

identified for respondents in 115 countries. The final number of countries included in the study was 107, as some contact details proved inaccessible.

Questionnaire

A questionnaire was developed using a combination of closed and open questions and rating scales. The questions were designed to gather information on:

- the key points identified in a recent IUHPE report on capacity in low income countries (3),
- issues on capacity development for Health Promotion identified in the literature,
- action areas identified in the Ottawa Charter (4),
- the competency domains developed by the Galway Consensus Conference group (5).

The questionnaire was piloted by sending a draft to one respondent from each of the IUHPE regions and, following revision, was made available to respondents via a link in an email to the Survey Monkey online research tool.

Response

Despite repeated email reminders and an extension of the deadline for returning questionnaires, the final responses numbered 37 which gave a response rate of 35% from across 107 countries.

Key findings include:

- The term most commonly used for health improvement activities in the majority of countries responding was Health Promotion.
- There was an identifiable Health Promotion unit or department in Ministries for Health in the majority of countries responding (78%) and dedicated posts with the title Health Promotion in slightly over half of the countries responding (58%).
- Health Promotion formed part of overall health policies for the majority of countries responding. However, 11% reported having neither Health Promotion policies nor Health Promotion input into other policies.
- Funding was available from both governmental and nongovernmental sources for the majority of countries responding but was generally described as limited, project specific and not sustained.
- 'Strengthening community action' was rated as the Ottawa Charter 'action area' most frequently employed in Health Promotion strategies.
- There was very strong support (94%) for a dedicated Health Promotion workforce with specialised training in all countries responding.
- The majority of countries responding reported the existence of education and training for Health Promotion and but also considered that the current provision was not adequate to build and maintain capacity for Health Promotion.
- The currently available education and training for Health Promotion was generally reported to be relevant and cultural appropriate.
- Less than a quarter of those responding had access to competency frameworks for Health Promotion.
- 58% of respondents rated accreditation for Health Promotion as important or very important.
- The core competencies for Health Promotion education and training which were rated as most important were 'enabling change' and 'knowledge competencies'.
- 'Basic foundation level courses' and 'continuing professional development courses for Health Promotion professionals' were rated as the types of education and training most required.
- Health Promotion practitioners, followed by primary care professionals, were rated as the highest priority target groups for training and education.
- Face-to-face lectures and workshops were identified as the most useful methods of delivery for education and training for Health Promotion, while distance learning through online courses materials was the least favoured method.
- 'Strong leadership provided by key individuals and organisations', followed by 'commitment of the existing workforce' were rated as the most important the existing strategies and assets in relation to capacity building for Health Promotion.
- The IUHPE was clearly identified as the organisation which should take a lead role in education and training for Health Promotion at regional and global levels, closely

followed by the World Health Organisation.

- 'Supporting the establishment of regional and national level training and education networks/ forums' was rated as the priority activity for the IUHPE in building Health Promotion capacity, followed by 'providing criteria for core competencies and professional standards'.

Conclusion

Despite a low response rate, the findings of the study provide a 'snap shot' of current capacity for Health Promotion and the training and education required to maintain and further build capacity in low and middle income countries across the IUHPE regions. The low response rate also limited in-depth comparison of findings across the regions, but the differences identified indicate the need for further investigation to ensure that future workforce capacity development is appropriate for different countries and contexts.

The opinions expressed by respondents on the roles which the IUHPE can play in supporting capacity development provide a useful basis for future strategies.

The report also includes a discussion of capacity development models and lists of education and training organisations globally. Recommendations for the future work of the IUHPE on workforce development, and on capacity development in general, are also included.

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The State of Health Promotion Practice, Research and Training in France: Better Days Ahead?

Eric Breton, Jeanine Pommier, Marion Porcherie, Elara Lima, Agnes Gindt-Ducros, Ngosse Diop

Introduction

In contrast with other Western European countries, the health promotion movement has made few inroads in the French public health landscape, a situation that has been repeatedly brought to the fore by a number of central public health figures and agencies.

In this paper we present a succinct account of the state of practice, research and training in health promotion in France through the lens of the guiding principles and action means stated in the Ottawa Charter. More specifically, we review the public health institutions and policies supportive of the Health promotion movement and the training programs offered. We conclude with a tentative prediction of the evolution of health promotion practice in France in the foreseeable future.

Methods

This account rests on three bodies of evidence. First, using two databases (BDSP and EbscoHost Medline), we collected articles published over the 2000-2011 period in two peer-reviewed French public health journals i.e. Santé Publique and Revue d'épidémiologie et de santé publique. All articles were retrieved using "health promotion" or "Promotion de la santé" as general search terms. We also hand-searched a must-read for practitioners albeit not peer-reviewed French journal: Santé de l'Homme.

The second body of evidence consists in a census of the training programs in health promotion/ health education offered at the university level in France. The programs were identified through two governmental websites, "Onisep.fr" and "inpes.sante.fr", and a general search of the Internet. Program coordinators were also interviewed to further document the content of the curriculum.

The third and last set of evidence comprises the core policy documents and mission statements guiding the main public health institutions in France.

We performed a content analysis of the data to appraise the extent to which the journal articles, training programs and the mission statements of the institutions are reflective of the principles and action means of the Ottawa Charter. Experts well acquainted with health promotion in France validated the results.

Results

France's Institutional landscape

It is no easy feat to render the complexity of the public health system in France. It encompasses numerous organisational actors whose actions rest on a constellation of sources of funding.

National level

All France's public health institutions are accountable to the 100 national public health objectives included in the 2004 National public health policy (République Française, 2004).

Mandated to implement the action plans and policies adopted by the central government, the National Institute for Prevention and Health Education (INPES) is the main engine for primary prevention program development and implementation at the national level. Over the years, the Institute has made its mark in developing an enviable know-how in mass media campaigns. Since its inception in 2002, the bulk of INPES resources have been invested in programs mostly resorting to health education and to the modification of social norms, leaving behind environmental interventions. INPES' programs also poorly address the social determinants of health, a situation that is no stranger to the restrictive disease prevention mandate defined by the legislation that created the Institute (République Française, 2002). Other agencies and ministries are also contributing to promoting health namely through social (e.g. childcare) and environmental policies (e.g. ban on smoking in public places).

Regional and local levels

In 2009, the regional public health landscape was significantly transformed by the adoption of a national policy to regionalise public health program planning and implementation (République Française, 2009). The policy entailed the setting up of 26 Regional Health Agencies (ARSs), including 4 for the departments and territories out of continental France. The ARSs bring under the same umbrella the administration of health care, medico-social services (e.g. handicap) and preventive services; they are now the main sources of funding for public health interventions at the regional and local levels. They are also mandated to develop Regional Strategic Health Plans (PSRS). As their first plans are still to be adopted, it remains unclear what weight will be given to health promotion within the ARSs' general business plans. One can also only speculate on the impact ARSs will have on existing agencies such as the IREPS (Regional Authority for Education and Prevention) and their local units: the CODES (Departmental Committee for Health Education). Although, the IREPS and CODES have been common features of all regions and departments of France since the 1970s, they are NGOs, not governmental bodies. With the regionalisation, the ARSs are now supposed to replace a number of funding organisations to provide a significant portion of the money received by the NGOs. However, and as a result of the reductions in government spending, the NGOs have already been subjected to significant budget cuts that are likely to impact on their activities.

An important and recent trend that should also be mentioned is the growing involvement of local communal administrations in health. Following the 2006 national urban policy, 237 urban health agencies (Ateliers Santé Ville) where created to address, in local populations identified as vulnerable, problems of access to health care services and also some core social determinants of health such as unemployment and housing (République Française, 2006). The degree to which social determinants are targeted varies greatly amongst the cities that answered the call to add health to their mandatory responsibilities.

Health promotion training and research

No health promotion PhD program is offered in France and only seven master's programs feature health promotion in their titles, although they appear to focus mostly on health education methods and theories. Five other master's degrees were identified, of which three were obviously centred on health education whereas two feature the more generic terms "public health" in their titles. Future analyses will show whether the latter five programs also address some of the other action means listed in the Ottawa Charter.

In spite of the large number of public health professionals intervening at the national, regional and local levels, the IRESPs are the only public health organisations that clearly embrace the spirit of the Ottawa Charter and as such the only ones that could be said to strive for the development of health promotion in France. There is no formal professional organisation devoted to health promotion and that could be said to bring together practitioners and researchers in order to improve the professional identity in the field.

As for research, only 15 eligible papers, published in the two aforementioned peer reviewed journals, explicitly referred to the Ottawa Charter. In the absence of a scientific journal in health promotion, researchers have no real arena for scholarly debates on the theories and concepts guiding health promotion research and practice.

Discussion

Health promotion appears to be still in its infancy in France. However a number of elements could facilitate its future development. First, practitioners seem keen to acquire the basics of health promotion principles and strategies as suggest the numerous requests the authors receive for continuous education. Second, INPES has recently started to provide funding for local organisations to implement comprehensive school projects to improve physical activity in children and for a research chair in health promotion at the EHESP School of Public Health in Rennes. Last, the problem of the social inequalities in health has in recent years moved to the centre stage and is now considered as a public health problem on its own; a development that could call for actions on the social determinants of health.

It is noteworthy that many cities in France have embraced the Healthy City movement and are linked together through a national network that receives part of its funding from INPES. However, the Republic is clearly lagging behind for what regards the

implementation of comprehensive approaches to health promotion in other life settings such as the schools and workplaces. Even though the spirit underpinning the WHO Healthy School project is globally captured by a 2001 policy to promote students' health, current practices are still oblivious of this model of school (Gindt-Ducros, 2006).

Although we are confident that our general account of the state of health promotion in France is valid, our results should be appraised in the light of the two main limitations of our methodology. Health promotion practice was assessed mostly through the lens of public health institutions at the national and regional levels leaving behind the work carried out by local NGOs and by agencies and ministries outside the health sector. Moreover, our journal search has yielded a general account of the national production but does not include French papers published in international journals.

Conclusion

Despite the numerous reforms that took place over the last decade within the French health sector, there is no indication that health promotion is going to make any significant breakthrough within public health institutions at the national and regional levels. If such a thing was to happen it is more likely to be at the local level, where communal administrations could take the lead by integrating health promotion as a legitimate component of their mission.

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The Chair on Health Promotion at the University of Girona as a Strategy for Capacity Building

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Introduction

In its general orientations, the University of Girona (UdG), in Spain, mentions its dedication to offer quality teaching, research and knowledge transfer. It also points out its social responsibility. The Chair is organized in Faculties, Departments, Research Institutes and Chairs. A Chair is defined as a unity that promotes study and research by organizing reflection, debate and diffusion activities. It has a university academic structure but with autonomous management. This duality allows recognizing its expert knowledge as it is recognized within the academic scope and at the same time it allows it to grow at regional, national and international level due to its autonomy. In 2008 a, Chair on Health Promotion was created by the University of Girona with the support of Dipsalut, the Public Health organism of the Regional Council of Girona.

This is the first Chair on Health Promotion within Spain and one of the first ones that is specific in Health Promotion at an international level.

This descriptive article wants to show the process of the Capacity Building of Health Promotion from the University of Girona by starting the Chair on Health Promotion.

Objectives

The objectives of the Chair on Health Promotion are:

- To create an adequate environment for health institutions of the region to specify and share their needs.
- To make health professionals sensitive to the importance of health promotion.
- To promote good practices in the institutions incorporating health promotion.
- To offer up to date health professionals training on health promotion.
- To transfer health knowledge to the community.

- To assess professionals and institutions on health promotion areas.
- To give easier access to the information resources according to the specific needs.
- To organize seminaries, workshops and conferences.
- To develop a virtual training space.

Description of the work done

A few historical elements

At UdG, research on Health Promotion (HP) started in the 90s as the doctoral thesis of one teacher of the University School of Educational Sciences. In 2002 the Research Group on Health and Healthcare, affiliated to the Nursing Department, was created. Health Promotion was then included as one of the group's lines of research. The Government of Catalonia as a consolidated research group acknowledged the Group in 2009.

Within the new framework of European Higher Education (EHEA), the creation of a Masters in Health Promotion was proposed in the mid 2000's by the Nursing Department. It started during the academic year 2007-2008 and its 4th cohort is currently studying as a multidisciplinary study.

Finally, in line with all the previous developments, the Nursing Department proposed, with the support of Dipsalut, the creation of the Chair on Health Promotion of the University of Girona that was approved by the Governing Council of the University in April 2008. A formal collaboration agreement with Dipsalut was signed on that same year for a four year period, which has recently been extended until 2014.

Activities of the Chair

The Chair on Health Promotion of the UdG has five types of activities in its services portfolio: training, publications, research, diffusion and transfer of knowledge.

Regarding training, different conferences, seminaries, workshops and summer courses have been organized, targeting at the same time professionals, students and health technicians willing to increase their knowledge and share their perspectives on health promotion.

As far as publications go, the Chair counts on over 3000 entries of documentary resources, which have been donated to the Library Campus of Health Sciences of the University. It has also started its own editorial collection, its first publication being the translation of the book "Hitchhiker's Guide to Salutogenesis", and is in the process of creating a periodical bulletin of health promotion.

Regarding research, an Associations Guide of Mutual Help has been elaborated as part of the project "Girona, a cardioprotected territory".

Finally, since its beginnings the Chair has wanted to promote the diffusion and transfer

of knowledge. Therefore, it has stimulated the constitution of the Catalan Network of Healthy Universities, as well as a Health Commission at UdG. In additions, it hosts the secretary of the Catalan Network of Health Promoting Hospitals and collaborates to diverse actions promoted by the International Union for Health Promotion and Health Education (IUHPE).

It has also established a collaboration agreement with the Patients University of the Fundació Robert of the Autonomous University of Barcelona, so as with the Latin American Consortium of Universities and Training Centers in Health Promotion.

Conclusions

Through the Chair on Health Promotion of UdG, it is now possible to plan and evaluate actions and community programs, give visibility to the activities carried out on training, scientific diffusion or transfer of knowledge as well as to draw together and give higher profile to the health promotion activities of regional the territory.

The activities of the Chair have counted with the participation of local, national and international renowned experts and it is our objective to promote and partake in the creation of national and international health promotion networks.

Finally, the has had the pleasure to participate and collaborate in numerous activities organized by other partners, always with the objective of creating synergies between different players in the fields of health in general and health promotion in particular.

For all of this we believe that Chair plays a very important role as a liaison between Latin America and Europe in the area of Health Promotion, especially in training and diffusion of Health Promotion, networking and establishment of synergies. We also think that profiting from the boosting of Mediterranean Area from the political grounds we can add up from the Health Promotion establishing alliances with institutions and Mediterranean professionals.

Furthermore Chair influence and disseminate Health Promotion within the same region, on the other side the institutions consider the Chair as an expert referent of Health Promotion, and therefore a consultant in many health activities.

We can then conclude that the Chair is a meeting point between professionals, citizens, politicians, at regional, national and international level which promotes networking in the field of Health Promotion.

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