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Ana Claudia Camargo Gonçalves Germani *Editors*

International Handbook of Teaching and Learning in Health Promotion

Practices and Reflections from Around the World

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Preface

How did the idea for this book come about? Who are the handbook's editors?

Between 7 and 11 April 2019, the 24th World Health Promotion Conference, organized by the International Union for Health Promotion and Education (IUHPE), was held in Rotorua in New Zealand. The theme of the Conference was "WAIORA: Promoting Planetary Health and Sustainable Development for All." The theme called for reflection on the methods, the content, and the competencies on how to teach and learn health promotion in the scope of higher education institutions, as it is a contemporary theme that requires analysis of how we have been conducting health promotion topics in our universities.

In this sense, a group of Brazilian colleagues submitted to the Conference's Scientific Committee an abstract for a workshop called "Let's share how we teach health promotion to undergraduates?" which was accepted by the Scientific Committee into the Conference Program. The intention was to open a dialogue with university lecturers from different countries (1) to share what teaching methodologies we university lecturers use in our undergraduate health promotion classes; (2) to discuss which competencies in health promotion we seek to achieve as a result of our teaching-learning processes; and (3) to produce a brief report that makes it possible to indicate research opportunities in the field of teaching-learning processes in health promotion for undergraduate students.

The workshop format made explicit the interactive intention of the activity, as it was suggested to organize conversation circles giving opportunity to all participants to express themselves about the teaching-learning processes with emphasis on the objectives (1) and (2), as stated above. The co-organizers were given the task of taking notes of the main discussion points. The workshop's term of reference aimed to achieve the following learning goals: (1) to learn about different experiences adopted by colleagues from other countries and institutions to improve our teaching toolbox; and (2) to critically analyze what professional profile in terms of health promotion we wish to produce by our teaching-learning process in the face of the changing world context.

Fig. 1 Photo of the group that attended the workshop on 8 April 2019, entitled "Let's share how we teach health promotion to undergraduates?", Rotorua, New Zealand, 2019.

We did not imagine we could count on such a wide participation, but we were positively surprised with a room filled with 42 researchers in attendance from different countries such as the Philippines, England, Indonesia, Israel, Canada, Australia, New Zealand, Singapore, and Brazil.

Each participant was encouraged to share content, methodologies, competences, and specificities, as well as the anguishes they carry, in a rich exercise of innovating in the different courses offered to various health professions. Additionally, discussion was held on courses in other areas of knowledge that have a strong interface with an expanded health concept, including fields such as architecture and urban planning.

Figure 1 shows the group of people from different countries and backgrounds. All concerned about teaching topics to expand the concept of health.

The level of enthusiasm and participation prompted a proposition to create an IUHPE working group on teaching health promotion. The receptivity of the IUHPE leadership to the Working Group on Teaching and Learning Health Promotion has enabled creation of this book, the *International Handbook of Teaching and Learning in Health Promotion: Practices and Reflections from Around the World*.

We, the editors and Springer, are pleased to make this handbook available to all those who want to make the craft of teaching and learning in the field of health promotion a tool that contributes to a more just world, that respects human dignity, and that adopts urgent measures to contain the climate crisis ravaging humanity. The COVID-19 pandemic has exposed the urgent need for the imperative search for such interdisciplinary, interprofessional, and intersectoral measures.

We, the editors, are from seven different countries (Canada, Belgium, Brazil, Israel, New Zealand, the United Kingdom, and Taiwan), and we are all university lecturers in ten different settings.

We worked in collaboration with the following:

Editors-in-Chief (Drs. Marco Akerman and Ana Claudia Germani), who have signed the publication contract and have been the editors responsible for all communication with Springer

Associate Editors (Drs. Stephan Van Den Broucke, Shu-ti Chiou, Lislaine Fracolli, Sylvie Gendron, Diane Levin-Zamir, Kate Morgaine, Júlia Aparecida Devidé Nogueira, Alfredo Almeida Pina de Oliveira, Dais Gonçalves Rocha, and Jane Wills), who have helped the editors-in-chief handle the chapters and organize each section of the handbook

Managing Editor (Andressa Anastacio), who was responsible for organizing all the material included in the complete manuscript of the book

We would like all readers to feel free to make contact with the members of the book's editorial board. For that, we provide, below, full names, email IDs, and names of our universities.

We keep talking!

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Acknowledgments

As pointed out in the preface, this book was born out of a workshop held at the 23rd World Conference on Health Promotion in Rotorua, New Zealand, 2019. In this regard, it is important to thank the International Union for Health Promotion and Education (IUHPE) for this opportunity, as well as for their support in disseminating the call and inviting interested parties to submit their chapters for the book. The book also features two vice presidents of the IUHPE Executive Council on the editorial board.

Bruno Fiuza, Springer Editor on Behavioral, Health, and Social Sciences, in Latin America, with his editorial base in São Paulo, Brazil, was a generous partner and very willing to guide the editorial steps towards the completion of this book.

Last but not least, we deeply appreciate the interest, dedication, competence, and collaboration in the editorial process of all authors who wrote and submitted their chapters for the book.

We hope that all readers who can get in touch with this book can enjoy its content, just as we editors enjoyed creating it.

Contents

Chapter 1
Introduction to the International Handbook of Teaching and Learning in Health Promotion: What and for Whom Is It Intended?

Marco Akerman, Ana Claudia Camargo Gonçalves Germani, Stephan Van Den Broucke, Shu-Ti Chiou, Lislaine Fracolli, Sylvie Gendron, Diane Levin-Zamir, Kate Morgaine, Júlia Aparecida Devidé Nogueira, Alfredo Almeida Pina de Oliveira, Dais Gonçalves Rocha, and Jane Wills

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What Has Been Written About "Teaching and Learning in Health Promotion"

In a brief review of what has been researched and written about "teaching and learning health promotion" within higher education institutions, we found items on the subject in a search of the NIH/PUBMED website with this search strategy (teaching [Title]) AND (health promotion [Title]) AND university OR higher education.

Although health promotion may be included as a keyword, often, the focus is, however, on public health or health education. There are also several recent papers and reviews on implementing the health promoting university that includes teaching and training in health promotion (e.g. Suarez-Reyes & Van den Broucke, 2016).

Several papers discuss the importance of, and content for, a health promotion curriculum for professions other than health (e.g. Furber & Ritchie, 2000) and for specific professions (e.g. for nurses, Mooney et al. (2011), Whitehead (2007); for doctors, Matthews et al. (2020), Maguire et al. (2017), Wylie and Leedham-Green (2017); for occupational therapists, Morris and Jenkins (2018)). Others even claim for an interdisciplinary workforce (e.g. Botchwey et al., 2009).

Many studies focus on the health behaviours of students but are descriptive studies of the behaviours or perceptions of university students concerning health-related issues, and few examine how these can be developed through teaching (e.g. Wills & Kelly, 2017).

Papers on the teaching of health promotion reflect their historical, political, and sociocultural context. It was discussed as early as 1982 in relation to teaching disease prevention (Lewis, 1982), but by the 1990s, Kelleher (1996) and O'Neill (1998) both argued that one of the challenges for teaching health promotion was that it lacked distinct disciplinary boundaries and therefore related content.

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Interestingly, articles published well after the Ottawa Charter in 1986 were still arguing for the need to include the values, principles, content, and fields of action of the New Health Promotion in curricula, and yet still expressed difficulties in implementing them (Poskiparta et al., 2000). At the turn of the century, there were attempts to integrate health promotion with community perspectives (Moch et al., 1999; Moshe-Eilon & Shemy, 2003), and more recently, a focus has been on how to teach evidence-based health promotion (Liabsuetrakul et al., 2017). Reflecting the shift to market-based economies, there are several papers on how competences and competency frameworks could, and possibly should, inform curriculum development so as to clarify professional expectations (Dean et al., 2014; Donchin, 2002; Madsen & Bell, 2012; Mereu et al., 2015).

Following the American College Health Association and the Practices for Health Promotion in Higher Education (https://www.campusdrugprevention.gov/sites/default/files/ACHA_Standards_of_Practice_for_Health_Promotion_in_Higher_Education_October2019.pdf), a few studies have focused on innovation in pedagogy and the need for more interactive and dialogic teaching (e.g. Willis et al., 1994) or the potential for using service learning (Reising et al., 2008). A review by Sadeghi and Heshmati (2019) of health education methods highlights the paucity of specialists in higher education, and perhaps, consequently, their studies are about teaching health professionals rather than health promotion.

There are a few case study papers on health promotion curricula developments (e.g. Duarte-Cuervo (2015) from Colombia; Idler et al. (2016), from Germany; Munoz and Cabieses (2008) from Chile; Poskiparta et al. (2000) from Finland), but as the next section highlights, a significant gap in the literature is contemporary critical reflection on where, how, and what should be taught in relation to health promotion.

What Is New in Our Book?

Publishers have many books on teaching and learning methods for health education/health promotion focusing on patients, families, and communities, or, more specifically, to develop needs and assessment capacity. We have not found any book specifically for lecturers teaching health promotion for undergraduate students or postgraduate studies in the courses of the health professions.

This book is about teaching and learning health promotion in the health professions undergraduate and postgraduate courses as well as other professions. It is suitable for related fields as Architecture, Urban Planning, Social Protection, Public Policy, International Affairs, Demography, etc. This book intends to share analytically what teaching methodologies we university lecturers from different countries use in our health promotion classes and other educational scenarios. It aims to discuss the competencies in health promotion we seek to achieve as an outcome of our teaching-learning processes and to indicate research opportunities in the field of the

teaching-learning process in health promotion for undergraduate and postgraduate students.

The handbook contains a description of the context of the experience and characteristics of the participants/students, professions, and courses involved; theories and methodologies used in the teaching-learning process; duration and frequency of activities; forms of assessment; results achieved, and challenges faced; analysis that includes the principles, pillars, competencies, or approaches to health promotion; and potential applicability of the experience in other contexts. This book is a lively and rich interchange of teaching- learning in health promotion ways between university lectures from different countries, involving different health professionals.

This is a unique book in that a university lecturer can read about the achievements, obstacles, and alternatives, which others have found to provide effective and attractive methods of teaching-learning health promotion, considering cultural sensitivity. Many say that active learning methodologies make university teaching more effective and attractive to students. But where to find someone willing to share their experiences as teachers in this regard? In this book, you will find colleagues willing to do this.

This book then follows up on the same concerns of the already published studies to improve our teaching effectiveness, bringing these concerns together in a systematized way by in organizing seven thematic sections:

I. The Health Promotion Curriculum
II. Making Health Promotion Relevant to Practice
III. Pedagogies for Health Promotion
IV. Special Topics for Health Promotion
V. Health Promotion Assessment and Quality Assurance
VI. Health Promotion as a Transformational Practice
VII. Students' Reflections

As you browse through the book, you will see that each of these sections is introduced by editorial notes highlighting the importance and content of each.

The World Changes and Demands Us to Change

This book opens dialogue with faculty from five continents (America – South, Central, North – Africa, Asia, Europe, Oceania) of the world (25 countries) who are authors of the chapters published here mediated by the 12 editors who are from Brazil, Belgium, Canada, Israel, New Zealand, the UK, and Taiwan.

1. Argentina – South America
2. Australia – Oceania
3. Austria – Europe
4. Belgium – Europe
5. Benin – Africa

6. Brazil – South America
7. Canada – North America
8. Colombia – South America
9. Cuba – Central America
10. France – Europe
11. Ireland – Europe
12. Israel – Asia
13. Italy – Europe
14. Mexico – North America
15. New Zealand – Oceania
16. Norway – Europe
17. Puerto Rico – Central America
18. Portugal – Europe
19. South Africa – Africa
20. Spain – Europe
21. Switzerland – Europe
22. Taiwan – Asia
23. UK – Europe
24. Uruguay – South America
25. USA – North America

The editors and authors of the chapters share their experiences aligned with the principles of health promotion. It encourages a dialogue between teaching and learning practices carried out locally and the possibilities of application and transformation from local to global reality, recognizing cultural differences and similarities.

Readers will be provided with real-world examples of empowering, participatory, holistic, intersectoral, equitable, and sustainable teaching/learning strategies that aim to improve health and reduce health inequities. The book is intended for a range of readers, including education and training providers, health professionals motivated to learn more, and public and private sector healthcare students. We believe that even civil society could join us in developing a common language and shared understanding and teaching of the key concepts and practices used in health promotion, locally and globally.

At the end of each chapter, you will find "Take-Home Messages" that reinforce the Handbook character and offer you six triggering questions for dialogue and reflection on the book's theme.

They are:

- What is your view on health promotion?
- What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?
- What theories and methodologies are used in the teaching-learning process?
- What forms of evaluation are applied, results achieved, and challenges faced?
- What principles, pillars, competencies, or approaches to health promotion underlie your teaching and learning plan?

- What could others learn from your experience? What is localized and what is "generalizable"?

We wish you all a good reading and fruitful reflections. Help spread the word that the teaching-learning process in health promotion is an effective, lively, engaged, and motivating way to contribute to the development of better professionals who are aware of the current challenges to expand the possibilities for producing better living conditions for all living beings – plants, animals, and humans – on Planet Earth. Let's also spread the word for the expansion of the concept of health in the current era of sustainable development!

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Part I
The Health Promotion Curriculum

Chapter 2
Introduction to Part I: The Health Promotion Curriculum

Jane Wills and Lislaine Fracolli

Contents

This part of the book focuses on the curriculum for health promotion, and in so doing, it highlights the ongoing challenge of differentiating health promotion as a discrete discipline. Health promotion is rooted in public health and is often seen as part of it, and yet what this section highlights is how it represents a radical shift from traditional public health curricula. The key distinguishing element is that health promotion is value driven and concerned with empowerment, equity and participation. It seeks to understand what contributes to health and to develop positive health for all, paying particular attention to those disadvantaged and to addressing the wider determinants of health. It tries to create participatory engagement, whether this is with individuals, students or communities, which enables those people to take control over the determinants of their own health.

This part includes six chapters. Two of the chapters are describing new initiatives – the first undergraduate programme in Switzerland (Chap. 3) and the first masters' programme in Francophone Africa (Chap. 4). Chapter 5 describes another new initiative which is a collaboration between Latin America and Europe to develop an online masters' programme. Chapter 6 outlines some of the issues and challenges facing the provision of health promotion education in the UK. Chapter 7 describes the programmes and health promotion modules at the University of the Western Cape, South Africa. Finally, Chap. 8 presents the experience at Curtin University (Australia) and the importance of close engagement between academic staff, industry stakeholders and students during health promotion course reviews.

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Each of the countries in this part point to the importance and necessity of a skilled health promotion workforce. Each of the universities providing an education in health promotion seeks to differentiate it from other healthcare courses that often sit alongside them in faculties of health. Whilst these courses such as medicine, dentistry, physiotherapy, occupational therapy and so on have clear regulatory requirements and career pathways, this is not the case for health promotion. The chapter on the UK (*Wills, Sykes, Trasolini*) shows how the descriptors of courses are rarely about health promotion alone and frequently aligned with public health. In Switzerland, the undergraduate course described here (*Biehl, Meyer, Nordstroem*) is called Health Promotion and Prevention; the Latin America/Europe collaboration course described here (*Bertolotto* et al.) is called Health Promotion and Social Development; and the course at the University of Western Cape is part of a master's course in public health (*Nyembezi, Delobelle, Mohamed). Wills*, *Sykes and Trasolini* highlight some of the risks associated with a lack of visibility for health promotion in nomenclature. Naidoo and Wills (2010 p. 7) distinguish health promotion as an area of practice, way of working and a field of study or discipline. The latter is distinguished by its focus (the promotion of health); its knowledge base (drawing principally from social sciences); its value base (empowerment, equity, participation, collaboration); its codes of conduct and ethics; and its history and traditions.

In this part of the book, examples are offered of courses and their curricula from the UK *(Wills*, *Sykes*, *Trasolini*), Switzerland (*Biehl*, *Meyer*, *Nordstroem)*, Francophone Africa (*Houéto* et al.), South Africa (*Nyembezi* et al.), Australia (*Blackford* et al.) and a collaboration between Europe and Latin America (*Bertoletto* et al.). Whilst each chapter describes different courses and at different levels and not all are singularly about health promotion, there is a remarkable similarity in the issues that are highlighted demonstrating that there is a shared understanding and unique identity of health promotion.

Many of the debates in these chapters mimic those mechanisms by which other professionals assert and exercise authority: the need to develop expert or specialist skills and knowledge and the establishment of certified levels of competence. What marks out all these health promotion courses is, however, their commonality of purpose. Whilst many other professional groups' values are articulated in codes of conduct about acting professionally, the beliefs, values and attitudes that underpin health promotion are articulated in the Ottawa Charter. The Ottawa Charter highlights three key health promotion strategies: advocacy to create the essential conditions for health, enabling people to achieve their full health potential and mediating between the different interests that influence health. It is the values of empowerment, social justice and participation that provide the conceptual, emotional and intellectual foreground for the development of a curriculum for the teaching and learning of health promotion. This is clearly expressed by *Bertolotto* et al. in Chap. 5 who describe a European/Latin American collaboration as underpinned by "an approach based on equity, equality, human rights and diversity of experiences". Chapter 7 describes the inception of public health and health promotion in South Africa with a vision to "contribute to developing policy-makers and implementers who are knowledgeable and skilled in the principles and practice of public health,

whose practice is based on research, influenced by informed and active communities, and implemented with a commitment to equity, social justice and human dignity". The tension or balance between an academic and professional orientation is highlighted in several chapters. *Blackford* et al. *describe the* evolution and process review of Bachelor of Science Health Promotion curriculum between 2002 and 2021, including different stakeholders. An important emphasis on best evidence and science is providing the framework for practice alongside a skills-based preparation for practice with several courses using the Comp HP framework to define the content through its definition of core knowledge and skills (Dempsey et al., 2011). The nature and scope of health promotion practice is briefly distinguished in these chapters. They suggest a difference between those courses in Northern countries where students are described as going on to careers in settings for behavioural interventions such as addictions or promoting physical activity and where communication skills are privileged. Students on courses in the South are more likely to come from another profession (e.g. medicine, midwifery) and go on to work in communities, and skills in project planning are emphasised. At all levels, there is an emphasis on students gaining practical experience through placements or internships, and these are a key feature of the courses described. Not only does this develop skills and an understanding of practice, but it can also help forge a professional identity as described in Chaps. 3 and 5.

Each of the courses outlines the participatory and empowering nature of the pedagogy that underpins the curriculum which is further explored in Part III. Teaching and learning is described as interactive with varied assessment types and with, in the case of Switzerland, South Africa, Australia and the Europe/Latin America collaboration in Chap. 5, a flexible approach to delivery including online, the provision of which is also discussed in Part IV.

Reflection by students and by staff is considered essential to develop and provide courses that are relevant to needs and which students consider how to apply learning to their work and life experiences. Chapter 7 outlines the principles of andragogy and the ways in which adults can be helped to learn. At UWC, there is a focus on the real world and examples of good practice in partnership working, community participation and health promoting settings.

Three of the courses here are relatively new and still in the process of evaluating their outcomes. They have all been developed in collaboration, either to draw from the expertise and experience of others or purposefully to, as in the case of Chap. 5 and the Europe/Latin America iProms course, challenge the "hegemony of European knowledge". These outlines of health promotion curricula make reference to establishing a community of practice. This is not only in forging future professionals who share values and views about the ways that health can be improved but also in the notions of knowledge, knowing and knowledge sharing that create that shared identity of health promotion.

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Chapter 3
The First Undergraduate Program in Health Promotion and Prevention in Switzerland: Context, Concept, and Challenges

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Contents

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Introduction

In this chapter, the undergraduate program in health promotion and prevention (HP[1]) at the Zurich University of Applied Sciences (ZHAW), School of Health Professions, is portrayed. Launched in 2016, it is the only program of its kind in Switzerland and has attracted attention as an innovative program for a young professional field. By the summer of 2021, the third cohort of students is graduating. While societal interest in HP is growing, its significance and recognition as a professional field have yet to be consolidated. Referring to the German-speaking part of Europe, to date, there has been no clarification of roles, competencies, or professional training and ethics in HP – in other words, no clarity about the profession of HP practitioners (Bals & Wulfhorst, 2008; Biehl, Gerlinger, et al., 2021; Göpel, 2006; Streckeisen, 2013; Walter, 2015). The undergraduate program builds on a vision of HP referring to the Ottawa Charter: HP focusing on socio-environmental determinants of health on a community level has the potential to support the most vulnerable groups in society. Health is produced in the environment where people live and work, which leads to the fact that health can be promoted in these environments via multiple stakeholders, e.g., families, schools, workplaces, or health professionals and in specific by HP practitioners. HP is seen as the field of action of public health (PH) with greatest practical relevance and therefore the need for special competencies in HP (Faltermaier & Wihofszky, 2011). HP focuses on promoting protective factors for health and creating supportive environments, whereas prevention focuses on reducing risk factors for health (Hurrelmann et al., 2018). Both concepts aim for maximum health gain and are understood as complementary fields of action within PH.

As outlined, HP is still in the process of being professionalized. In this process the IUHPE is the driving force in that it promotes the dissemination of evidence-based knowledge to the HP community and the advocacy for HP (Van Den Broucke, 2020). There have been great achievements for HP since the Ottawa Charta, e.g., its own concepts and values, a specific competency framework (CompHP) (Dempsey et al., 2011), university programs, handbooks, journals, conferences, an expanding accreditation system for HP practitioners and programs, and the implementation of HP in political health agendas (e.g., SDGs, national laws on health promotion and prevention) (Nutbeam, 2019; Ruckstuhl & Ryter, 2017; Van Den Broucke, 2020; WHO, 2017). Besides these achievements and enablers of professionalization of HP, some barriers have been recognized: a lack of institutional structure, no sustainable financing, competing interests in the health sector and beyond, a lack of visibility of HP, or the complexity of HP conceptualization (Barry et al., 2020; Barbara Battel-Kirk & Barry, 2019a; Van den Broucke, 2021). Moreover, the need for a stronger HP workforce is justified by a still lacking quality of HP practice (Barbara

[1] To our understanding, health promotion and prevention are complementary fields of action within public health who both aim for maximum health gain. In this chapter, we use the abbreviation HP referring to both health promotion and prevention.

Battel-Kirk & Barry, 2019a; Golden & Earp, 2012; Reisig et al., 2016) and lacking HP practitioners (Hommes et al., 2020; Paccaud et al., 2013). There is a growing call for action of the HP community and workforce to further implement HP in practice, research, and politics (IUHPE, 2021).

This undergraduate program at the ZHAW in Switzerland tries to ensure an ideal teaching-learning setting for HP, focusing on great practical training opportunities (work placements), skills training (research methods, project management, and communication), and an interprofessional training involving other health professions. This program in HP wants to contribute to the professionalization and capacity building by training professionals for a research-based, practice-oriented, and interprofessional approach to HP. This chapter depicts the undergraduate program in HP regarding its context and the program concept. Experiences with 5 years of program implementation are described including major challenges, visions for future steps, and transferability to international contexts.

Institutional and Political Context

Professionalization processes, especially in HP, depend on the political and institutional contexts. Switzerland has about 8.5 million inhabitants in four different language regions. Despite a very high life expectancy and a good health status of the population in Switzerland, there are certain challenges for the healthcare system, such as noncommunicable diseases (NCDs), mental illnesses, and an aging society. Diseases and health behaviors are very unequally distributed in Switzerland. Furthermore, there is an unequal distribution of resources and unequal access to health services. There is also a lack of epidemiological data on certain diseases and their consequences in Switzerland, which is the basis for deriving needs-oriented measures (BAG & GDK, 2016; De Pietro et al., 2015). The main responsibility for PH lies within the 26 different cantons (16,000 to 1.5 million inhabitants), whereas the national level has mainly coordinating tasks. Overall, there is a need for experts such as HP practitioners who can address these described challenges and advocate for health equity.

In Switzerland, HP was pushed forward in 1990 by establishing the foundation "Health Promotion Switzerland." The main aim was to tie in and coordinate cantonal activities in HP. Since 1996, the foundation has been financed by the compulsory health insurance of every citizen in Switzerland with 2.40 CHF per year. In 2018 this amount was doubled to 4.80 CHF per year to better deal with rising NCDs and mental health issues (BAG & GDK, 2016; Schuler et al., 2016). "Health Promotion Switzerland" is the national representative of HP, advocating for HP, initiating, financing, coordinating, and evaluating programs (Oggier, 2015; Ruckstuhl, 2017). This progress is only achievable in collaboration with other main stakeholders of HP, like health leagues (e.g., cancer, AIDS), health insurances, the Federal Office of Public Health, and the 26 Swiss cantons. Since 2000, every canton has been represented in the national "Consortium of Cantonal Delegates of Health

Promotion" (VBGF) to further coordinate HP activities at the regional level in every canton (De Pietro et al., 2015). This consortium is an important stakeholder for the professionalization of HP as it advocates for HP at national and regional levels (Müller, 2020). Further important stakeholders in the field of HP are different NGOs. Their work is financed by the public administration as well as by private donations. Moreover, the Swiss School of Public Health (SSPH+) founded in 2005 is to be mentioned as a stakeholder for the professionalization of HP, which today consists of 12 Swiss universities promoting postgraduate education and research in PH (SSPH+, 2021). Finally, "Swiss Public Health," a professional association founded in 1972, is mentioned due to their engagement for PH professionals and advocating for PH. HP is part of this association and is constituted as a specialized subgroup of the association (Public Health Schweiz, 2021).

Despite this institutionalization of HP in Switzerland as a strong enabler for the professionalization of HP, there are also barriers to be faced, three of which are to be mentioned here: First, there is a massive lobby (mainly from the alcohol and tobacco industry) combatting capacity building of HP (AWMP, 2008). This was demonstrated when in 2012 a draft law on HP was rejected (De Pietro et al., 2015; Ruckstuhl, 2017). Second, the expenditures on HP in Switzerland are below Organisation for Economic Cooperation and Development (OECD) average. 2.4% of all health expenditures are spent on HP compared to an average of 3.1% in the OECD (De Pietro et al., 2015). This demonstrates the medical orientation of the health system in Switzerland. And last, the structure of the political system in Switzerland consists of very different 26 cantons. They are responsible for their local health system, but the concrete solutions to deal with this responsibility are very different. Cultural and political reasons have led to 26 different approaches to reach PH.

HP Workforce in Switzerland

There are only a few studies on the HP workforce in Switzerland. About 10,000 people work in the field of PH, 40% of them in HP, without calculating HP in the workplace setting. Only 1/3 completed a professional training in PH or HP, and therefore a majority are lateral entrants to this field of action (M. W. Frank et al., 2013; Paccaud et al., 2013). There is a lack of a young professionally trained PH workforce in Switzerland, which includes HP (Bucher & Meyer, 2013; M. W. Frank et al., 2013; Heusser & Weihofen, 2014). In 2020, a situation analysis identified specific recommendations for the work profile of the cantonal delegates of HP. The analysis indicates a great lack of personal and financial resources of HP at the cantonal level (Müller, 2020).

Professional Training in HP in Switzerland

In Switzerland, first educational programs in PH started in the 1990s. A great variety of PH-related programs ranging from sport sciences to health sciences were established at undergraduate and postgraduate level as well as in continuing education programs at different universities and institutions (Heusser & Weihofen, 2014; Ruckstuhl & Ryter, 2017). PH-specific programs are only available via continuing education programs and a specific PhD program offered by the SSPH+ (Heusser & Weihofen, 2014). The same was the case for specialized programs in HP, which were only available via continuing education programs mainly established at universities of applied sciences at departments of social work. In 2016, the first undergraduate program in HP was established at the ZHAW, which is the subject of this chapter. The ZHAW is Switzerland's largest multidisciplinary university of applied sciences, with over 12,000 students. The School of Health Professions of the ZHAW is a renowned center for teaching, continuing education, and research in the German-speaking context. The university offers undergraduate programs in occupational therapy, midwifery, nursing, physiotherapy, and HP as well as some postgraduate programs. The undergraduate program in HP is run by the Institute of Public Health. To comply with international standards of HP, the undergraduate program is based on the CompHP (Dempsey et al., 2011). This competency framework is an essential development in the professionalization of HP, because it enables transparency, comparability, and quality assurance of HP education, practice, and policy (Barry et al., 2012; Barbara Battel-Kirk & Barry, 2019b; Dempsey et al., 2011).

The establishment of the undergraduate program at the ZHAW was an important milestone in the professionalization of HP and PH in Switzerland (Ruckstuhl, 2017), even though further developments in the professional education of PH and HP are necessary, e.g., foundation of undergraduate courses in the Romandy (French part of Switzerland) or postgraduate courses in HP and PH.

This short description of the institutional and political situation of HP in Switzerland is of relevance for contextualizing the undergraduate program in HP described in this chapter. In the following section, the undergraduate program in HP at the ZHAW is portrayed.

The Undergraduate Program in HP at the ZHAW

The Major Hallmarks of the Program

The program (180 ECTS) is offered as a full-time (3 years) and part-time (5 years) study program and qualifies for a Bachelor of Science in HP. It accommodates 66 full-time equivalents per year. The number of part-time students amounts to approximately 25% of the total enrolled students. The program encompasses modules of six different subject areas: (1) theory and foundations of HP (33 ETCS), (2)

communication and transformation (30 ECTS), (3) consolidation and transfer (42 ECTS), (4) scientific work and research methods (24 ECTS), (5) practical training (incl. work placements) (36 ECTS), and (6) interprofessional training (15 ECTS). The professional competencies of the undergraduate program are formally explicated by the CanMEDs model, as this is the general framework for all study programs at the School of Health Professions of the ZHAW (Frank, 2005; Ledergerber et al., 2009). To comply with international standards of HP, the CompHP was integrated content wise in the seven professional roles of the CanMEDs model (see Fig. 3.1).

As mentioned before, teaching and learning HP as a complex professional profile is a great challenge to both lecturers and students. To ensure the interdisciplinary approach of HP, lecturers with various professional backgrounds are involved in the undergraduate program teaching different modules, e.g., social workers, psychologists, sociologists, and ethnologists. Most of the core team of about 15 persons involved in the undergraduate program do have either practical experience in HP or a research-oriented background in HP.

Students Enrolled in the Program

To ensure a certain level of maturity and work experience in a health-related field of action, the undergraduate program in HP has a twofold admission procedure. On the one hand, prospective students with a baccalaureate must pass a two-part aptitude assessment: a written cognitive test and an oral test for social and communication skills. Based on the results of the two tests, a ranking list is made, according to

- As **Experts**, graduates assume professional leadership for the planning, implementation, and quality assurance of population-based health promotion or prevention interventions.
- As **Communicators** graduates engage adequately with different reference groups of the population to address health promotion and prevention.
- As **Collaborators** graduates actively engage in interprofessional teams.
- As **Leaders** graduates conduct evidence-based health promotion and prevention interventions and evaluate their effectiveness.
- As **Health Advocates** graduates apply adequate strategies to promote health equity.
- As **Scholars,** graduates commit themselves to lifelong learning and the development, dissemination and application of knowledge in health promotion and prevention.
- As **Professionals** graduates continual reflect their practice and promote the professionalization of the professional field of health promotion and prevention.

Fig. 3.1 Shortened version of the professional competencies of the undergraduate program in health promotion and prevention at the ZHAW based on the CanMEDs model and the CompHP framework

which the 66 study places are allocated. On the other hand, work experience within a so-called extended health sector of a minimum of 2 months duration is a prerequisite for those who want to enroll into the program. This may consist of positions within a care institution, a pedagogic institution, or within fitness or sport. It may contain work experience with patients, clients, pupils, or customers in the widest sense. Before completing the undergraduate program, students have to have 12 months of work experience in total, out of which 8 months must be completed in this extended health sector. The remaining 4 months may be from any work experience.

The students are quite heterogeneous regarding educational background and age. About 2/3 do have prior vocational training and work experience, mainly in the health sector (e.g., nursing, pharmaceutical assistants) or in the economic sector (e.g., business administration, retail). Other students directly enter the study program after graduating from High School. The students are quite homogeneous regarding gender (mainly female), place of residence (German-speaking part of Switzerland, mainly close to Zurich), and nationality (mainly Swiss, some Italian and German). Further details on students of the undergraduate program in HP are described in Table 3.1.

Methodological Approach in the Teaching-Learning Setting of HP

Being part of the ZHAW, the undergraduate program in HP is committed to train professionals who are both familiar with the practical aspects of the field and well trained in a research and evidence-based approach to HP, as well as being embedded in the School of Health Professions, which means being part of a wider academization process which has taken place in health professions in Switzerland since 2006 (Oggier, 2015; Ruckstuhl, 2017). The School of Health Professions at the ZHAW runs five undergraduate programs, which are all based on a competency-based concept of education defined in seven professional roles (see Fig. 3.1 for HP) (Ledergerber et al., 2009; Spiegel-Steinmann et al., 2021). Thus, the content of the

Table 3.1 Sociodemographic data, number of students and dropouts in the undergraduate program in health promotion and prevention at the ZHAW in Switzerland

Year of study cohort	Number of students	Form of study program (full-time)	Number of dropouts	Gender (female)	Median age at program beginning (min–max)	Prior vocational training
2016	46	46 (100%)	5 (11%)	36 (78%)	23 (19–38)	27 (59%)
2017	36	33 (92%)	5 (14%)	31 (86%)	23 (22–29)	23 (64%)
2018	52	46 (88%)	7 (13%)	48 (92%)	23 (20–45)	33 (63%)
2019	57	45 (79%)	3 (5%)	51 (89%)	24 (18–39)	46 (81%)
2020	59	47 (80%)	7 (12%)	51 (86%)	23 (19–39)	40 (68%)

program is aligned with a focus on three clusters of methodological approaches: (1) practical training, (2) skills training (research methods, project management, and communication), and (3) interprofessional training. This mixture of competencies and methodological approaches shall ensure graduates being able to conduct programs based on the setting approach including behavior change programs and programs focusing on structural prevention elaborated with participation of the community.

In order to comply with constructive alignment, different modules focus on different formats of assessments to reach the learning outcomes/competencies of the undergraduate program. As collaboration is an important competence in HP, many assessments must be passed in group work. Depending on the subject, different assessments are applied in different terms of the program, e.g., oral presentations, written term papers, epidemiological factsheets, and applying research methods, e.g., interviews, focus groups, and surveys. At the same time, individual work is produced, e.g., reflection reports, written exams incl. multiple-choice or open-ended questions, and the bachelor thesis, which is usually written in relation to the work placements. Generally, the teaching-learning setting is supposed to follow the principles of HP. This means the lecturers are committed to creating a supportive environment for students and enabling participation and empowerment in the courses and the program where applicable. Moreover, it is a special interest to promote social equity and therefore promote students with greater challenges, e.g., mental health issues or reconciliation of family and studies.

The following sections focus on the main methodological approaches of the teaching-learning setting within the undergraduate program in HP.

Practical Training

HP as the field of action within PH with the most practical relevance needs to be taught and learned in a setting enabling practical experiences. Practical training permeates the entire program. As outlined, most lecturers have extensive experience as practitioners in the field of HP (e.g., addictions prevention, workplace HP, community-based HP) or research-oriented experience in HP. This practical background of the core lecturers as well as of external lecturers from the practice ensures high practical relevance of the theoretical perspectives and skills training in the undergraduate program in HP. This enables networking and discussions between students and experts in HP from the beginning of the program. In the first term, there is a module which offers students the opportunity to visit three to four organizations in the HP sector. This is their first insight into HP practice and the starting point to network with experts in the HP field in Switzerland. In the second term of the undergraduate program, various partner organizations are presented in order to give students insight into the variety of target groups, strategies, organizations, and employees of the HP field.

During the first years of the undergraduate program, a major effort has been made to build a network of partner practice organizations in the HP field, to be able

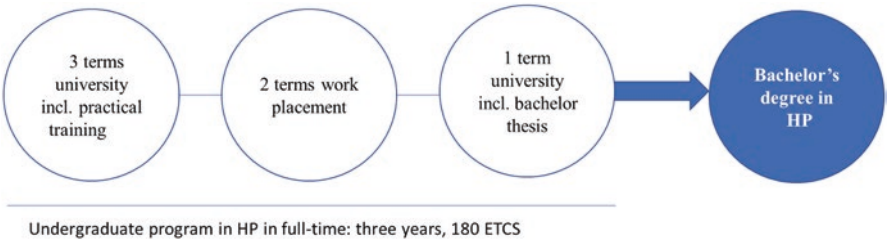

Fig. 3.2 Graphical structure of the undergraduate program in health promotion and prevention at the ZHAW in Switzerland

to offer work placements to students. In 2021, we will have more than 80 partner practice organizations in various fields of HP who offer work placement positions to students. The work placements take place in the second half of the undergraduate program lasting between 6 and 9 months depending on the workload of the job positions. Starting in the third term of the undergraduate program, students are continuously prepared to choose their work placements and apply for them, which is seen as a great opportunity to practice future application procedures in the real job market. More than 800 h of work placement within the undergraduate program at one practice organization enables a deep insight into a specific field of HP and the tasks of the HP practitioners. Students are coached and supervised both by lecturers of the undergraduate program and mainly by their practical educator within the practice organization. Agreement on specific aims of the work placements and their evaluation relies on the competency framework of the undergraduate program based on the CompHP (Dempsey et al., 2011). To ensure theory-practice transfer, students come back from the work placements to university for their last term before graduating. Figure 3.2 shows the approximate structure of the undergraduate program in HP.

A special feature of the practical education is the recently started Center for Therapy, Training and Consultation (Thetriz) on the campus of the School of Health Professions at the ZHAW. The Thetriz was launched as a common center for all undergraduate and postgraduate programs at the School of Health Professions and offers the opportunity of practical training on campus. Thetriz is open to the public and offers treatments, consultations, and workshops to patients and clients. Students are involved as observers and are given the opportunity to learn and test professional and interprofessional situations under the guidance of experts. Moreover, students in HP at the end of the program will, for example, elaborate community-based HP projects; conduct, e.g., workshops on stress reduction; or launch programs for various vulnerable groups depending on the demands of the community and practice organizations.

Skills Training

Another methodological approach to teach and learn HP is the strong focus on skills training necessary for HP. Therefore, communication skills as well as research methods are central competencies (Dempsey et al., 2011). Communication modules

are rolled out throughout the whole undergraduate program including public communication, interpersonal communication, health communication, and social marketing and communication management in projects. Furthermore, the interprofessional training also focuses on interprofessional communication. For example, students participate in workshops, where they train interpersonal communication, such as motivational interviewing and negotiation skills. In some of the workshops, professional actors are engaged for the skills trainings. Moreover, they also practice written communication skills to specifically train target-group-oriented language. Communication skills are the basis of adequate acting in HP, either in behavior change programs or programs on structural prevention.

Extensive focus is upon students' capacities to develop and manage evidence-based projects. The undergraduate program thereby not only aims at enabling future HP professionals to make a sustainable impact but also promotes the reputation of the professional field in general. Teaching in research methods is part of both interprofessional training and profession specific classes. Quantitative and qualitative research methods are taught not only theoretically but are also applied by students or students are active participants in research projects. Especially in the bachelor thesis, students have to prove good knowledge of a scientific approach to the HP themes. Most of the theses are based on empirical studies conducting interviews, focus groups, or small surveys which directly contribute to quality assurance of HP practice in Switzerland as most bachelor theses are elaborated within the work placements.

To effectively work in an evidence-based way in HP following the Public Health Action Cycle, students also gain knowledge in evidence-based project management and evaluation methods. Several modules that are connected to the research methods modules focus on teaching and practicing procedures and tools for planning, implementing, and evaluating evidence-based projects in HP.

Since the start of the undergraduate program in 2016, a project has investigated the professional identity formation of the undergraduate students of HP at the ZHAW. Therefore, students are asked to complete an online survey at three measurement points throughout their undergraduate program. In addition, focus groups are conducted with the students at the beginning and end of their undergraduate program discussing their professional identity formation in HP. This approach enriches the program in two perspectives. On the one hand, students are actively involved in a research project and experience different research methods relevant to the field of HP. On the other hand, the results of the continuing online survey and focus groups enable deep insight in students' promoting and inhibiting factors of professional identity formation within the undergraduate program of HP, which is part of a continuing evaluation process of the undergraduate program (see Biehl, Wieber, et al., 2021). Further results will be published in the upcoming years.

Interprofessional Training

Communication and cooperation with various disciplines and professions in the sense of "learning with, from and about one another" is an integral part of all interprofessional training (Spiegel-Steinmann et al., 2021). Thus, in addition to subject-specific modules, students of all undergraduate programs at the School of Health Professions participate in interprofessional modules. These account for roughly 1/8 of the undergraduate program in HP. The reason for this high percentage of interprofessional modules is not only the promotion of mutual understanding among the different professions but also a conviction that health professions in the course of academization need to be interlinked. For HP, this interdisciplinary education supports future competencies of intersectoral and multidisciplinary collaboration, which is central in HP (Gagné et al., 2018; WHO, 1986).

For this purpose, the School of Health Professions has developed its own concept for interprofessional training, WIPAKO®. It facilitates the acquisition of communicative and social competencies as a prerequisite for good collaboration between health and medical professions. Mutual understanding and insight into different perspectives is the core of interprofessional training, the benefits of which are seen both among students and staff. Organized through joined responsibilities between the different professional undergraduate programs at the School of Health Professions, WIPAKO® was developed with a focus on shared expertise within the different health professions (Spiegel-Steinmann et al., 2021). Some of the themes covered in the interprofessional training are managing demanding communication settings, interprofessional collaboration in various (care) contexts, exchange on ethical issues in the interprofessional discourse, collateral leadership, and research methods.

Challenges During 5 Years of Program Implementation

Despite all challenges faced, we can conclude from oral and written feedback within evaluations of modules and the focus groups conducted that the undergraduate program so far can be valued as a success for most students, lecturers, and practice organizations. Students and lecturers are widely satisfied with the learning outcomes and results of the different assessments. Commonly great feedback is also derived from the practice organization regarding the work placements, which seems to be very adequate for both students and practical organizations. Moreover, we have anecdotal knowledge of many graduates who are successfully employed in the HP field, e.g., addiction prevention, community-based, or workplace HP. Some of them are already in leading positions in the HP field. After graduating, many students also entered postgraduate courses in Switzerland or abroad which further promotes the professionalization of HP in Switzerland.

While the HP undergraduate program has attracted the interest of many students and professionals, we envision a greater impact for the education sector and the HP field. After 5 years, we have devoted ourselves to build on lessons learned so far and

to take the program some steps further. For the current process of consolidating and developing the program, we have identified three areas of attention: form of study, employability, and the complexity of teaching and learning HP. The focus groups conducted with all study cohorts allow important insights in students' perspectives on the undergraduate program. At the end of each following section, we outline the transferability of our challenges to international contexts.

Form of Study

Nowadays, many students find themselves in situations where they want or must combine studying with a part-time job. Therefore, the population of people who are interested in the undergraduate program in HP consists both of prospective full-time and part-time students. So far, the demand for an opportunity to study and work at the same time has been met by an offer of two types of study models, a full-time program with a total length of six terms and a part-time program with a total length of nine to ten terms. Recent registrations confirm the trend toward a continuously strong interest of the latter. Among the applicants for the fall 2021, 25% apply for the part-time program. For details of the number of students enrolled in the undergraduate program, see Table 3.1.

However, accommodating the two types of study models within one undergraduate program has proven to be costly regarding personal resources. While students from both study models have been mixed in the classroom, accommodating the part-time model in the schedule of the program is a complex matter. As a result, the schedule and workload of the part-time model have varied over the terms, which has caused bottlenecks for students in their work life. Furthermore, the average dropout throughout the first 5 years has been at 9.5% for the full-time model and at 26.5% for the part-time model. The percentages must be taken with caution, since it is a small number of students (n = 250), but they seem to indicate that the part-time model has not been as satisfactory or convenient for the enrolled students. Even if there is reason to believe that there might be different reasons for this, on our part, we have committed ourselves to attempting to improve satisfaction regarding studying part-time.

In order to improve this situation both in terms of student flexibility and satisfaction, as well as saving on staff resources, the undergraduate program in HP as a whole will be revised in terms of a "flex model," accommodating both full-time and part-time students in a more flexible program. In the envisioned flex model, the program will be divided into three segments or phases: basic modules which form a starting phase, where basic modules offer an introduction to the field of HP; the completion phase, where work placement and bachelor thesis are at the core; and an intermediate phase between these two, where the main part of the professional and interprofessional knowledge and skills is acquired. In the latter, modules may be studied in a flexible order and at an individually adjustable pace. The vision is built on some pillars, yet to be defined in detail: No definite study duration is set. Thus,

within a flexible span of time, students are given the possibility to plan and distribute their workload along their personal life situation. To a large extent, teaching will be done with flipped classroom didactics, where students engage in explorative and inquiry-based learning (Akçayır & Akçayır, 2018). The program offers a variety of compulsory electives, where students can engage in topics of their choice.

Today, students can make only very few choices within the set of compulsory elective courses in the interprofessional part of the curriculum. In effect, students acquire a standard bachelor's degree with generalist competencies. The program thus demonstrates a clear school-based approach. While this ensures broad knowledge of HP and suits some students, others have a clear interest in specializing in more specific areas, settings, or target groups. To encourage personal preferences within the HP field and to empower students to more self-directed learning, the vision for a flex-program has been developed. The challenge will be to offer a standard program while at the same time opening up for more space and opportunities to form one's education in accordance with one's own preferences with regard to content and form of study. Students will be given choices with regard to content, study pace, learning methods, and examination. This way, they also choose whether to cover more topics and thus to obtain a broader education or to delve deeper into a specialization area of their choice. These adaptations are in line with the principles of HP as a basis for the undergraduate program. The university wants to ensure a healthy environment for their students and enable more participation and empowerment processes by planning their individual study schedules.

This shift toward more self-directed learning is transferable to universities offering undergraduate and postgraduate programs in HP in the global north, who deal with similar societal and institutional contexts. Therefore, the experience within our program contributes to the international discussion on the ideal teaching-learning setting for HP education.

Employability

The main challenge within the practical field of HP is to gain recognition for a still unknown profession. In our experience, there is a high awareness of future career possibilities among young people, and their choice of education programs is clearly led by or accompanied by a concern for future employability. The focus groups conducted with all study cohorts at the beginning and end of their program reveal a certain amount of anxiety about their future job possibilities. Some students obtain job contracts at the work placement, which has a promoting effect on professional identity formation also for their fellow students. Others fear bad job opportunities after graduating (Biehl, Wieber, et al., 2021). These insecurities have been revealed in similar studies in the field of HP (Karg et al., 2020; Walter, 2015). Karg et al. (2020) suggest supporting and coaching the students during their program to build their specialist profile within the HP profession during the undergraduate program and thus to promote their job opportunities. The new and partially unexplored job

market in HP in Switzerland demands flexibility, self-branding skills, and profiling from new graduates. During the undergraduate program in HP at the ZHAW, students develop very generic skills in interpersonal and public communication or research methods, which can also be adapted to other work sectors. This is also appreciated by the students. During the preparation for the work placements, students are given some coaching on application skills, which is also helpful for their future job applications. In addition, there is a specific module within the undergraduate program called "professional education," where students specifically focus on the distinction of their competencies in HP comparing similar professions of the wider PH workforce. Within the module, job advertisements in HP are examined regarding their specific competency profile preparing the students for their future job situation and supporting their professional identity formation in HP.

Surveys with graduates of undergraduate programs in HP in Germany reveal good employability (Sachs & Hochschule Neubrandenburg, 2014). These graduate surveys are elementary for analyzing the job situation of the future HP workforce and are the basis for supporting students in the transfer from student to professional. In the near future, these graduate surveys are also planned with our graduates in HP to better evaluate the employability of the graduates.

In this regard, the undergraduate program in HP forms a "special" case among its fellow undergraduate programs at the School for Health Professions. While job opportunities and careers are quite set in health professions, HP graduates have to be proactively engaged in their career. While possibilities of specialization are many, they have to find and specialize in a profile of their choice. When students compare themselves with students in the nursing program, for instance, their career prospects naturally appear less certain. Furthermore, for many job occasions, HP graduates have to compete with graduates from other professions (e.g., social work, teaching, psychology).

Literature indicates low publicity and low workforce capacity of the HP profession in many countries worldwide (B. Battel-Kirk et al., 2009; Barbara Battel-Kirk & Barry, 2019b; Van den Broucke, 2021). Raising awareness and publicity of the HP profession promotes capacity building and contributes to better employability of graduates of HP programs. The undergraduate program is internationally connected, so is the School of Health Professions at the ZHAW. By addressing this pressing issue in Switzerland, we contribute to raise publicity and capacity building of the HP profession also internationally. Further international collaboration with the IUHPE and German speaking countries would foster these professionalization processes of HP and raise employability in longterm.

Complexity of Teaching and Learning HP

The professional profile of HP is hard to capture for students of undergraduate programs (Biehl, Wieber, et al., 2021; McKay & Dunn, 2015; Zocher, 2013). Core elements like the holistic perspective on health focus on populations instead of

individuals, intersectorality and strategies like advocating, mediating, or enabling make it a very complex professional profile as recognized in the literature (Biehl, Gerlinger, et al., 2021; Keshavarz Mohammadi, 2019; McQueen et al., 2007; Tremblay & Richard, 2014). This complex nature of HP is underlined by the fields of action proposed by the Ottawa Charter (WHO, 1986). Of course, this complexity is not easy to grasp for undergraduate students and explains their confusion about professional responsibility and the scope of their future profession. The results of the focus groups conducted at the ZHAW indicate that some students can handle this complexity, which becomes clearer in the course of the study program. The great variety of HP is even seen as an asset by most students. . Some students are overwhelmed by this complexity and therefore are dissatisfied with their professional choice (Biehl, Wieber, et al., 2021).

Being part of the School of Health Professions means being in a context with expertise in different healthcare settings. The school is committed to an integrating and broad health sciences perspective, which is an extremely stimulating home base for the undergraduate program in HP. However, in one sense, the HP perspective constitutes a different perspective with divergent foci, teaching, and learning methods. From its start, the program has strongly focused on a PH perspective with an emphasis on socio-environmental determinants of health. Students are primarily trained in working on an organizational level, addressing stakeholders and policymakers since the primary focus of HP are communities instead of individuals. Mostly, the program educates for structural change and policymaking, focusing on environments, societal and financial structures. Clients may be individuals, groups, or organizations within different settings. Only partially students deal with personal, face-to-face interaction. Skills on an interpersonal level, such as coaching or consultation, are only a marginal aspect of the undergraduate program in HP. However, a need came up by students and some lecturers to put more focus on these skills as part of the HP competencies regarding behavior change interventions. Moreover, focus groups revealed that students often imagine a different professional profile within HP, referring to working more directly with the target groups. At the ZHAW, School of Health Professions, a gap between an individualistic and a public health perspective on the role of HP practintioners is evident.

There is a need to elaborate a clear vision and common understanding of the professional profile of HP among the lecturers at the whole university and the students and within policy and practice of HP in Switzerland. It is challenging to implement a new undergraduate program in HP with team members with different professional backgrounds. Establishing a common vision of the undergraduate program in HP takes time and involves a reflection process within the team. Therefore, the CompHP is assumed to be a very suitable tool to promote a common understanding of competencies of HP practitioners. As an educational institution, we do have to contribute to this publicity of the professional profile of HP. These activities advocating for HP should be supported by the workforce and by institutions of HP like a specific professional association of HP, which does not yet exist in Switzerland.

This complexity of learning and teaching HP is surely comparable to similar educational institutions teaching HP worldwide. Therefore, the measures taken

within the HP program at the ZHAW are comparable to other educational institutions. CompHP can help to foster a common understanding of HP and specific competencies of HP practitioners. Further investigations on teaching and learning settings in HP programs are necessary to find solutions to achieve best learning outcomes and a strongly identified HP workforce.

Conclusion

Five years after the implementation of the first undergraduate program in HP in Switzerland have revealed both success and challenge. Students and lecturers are widely satisfied with the learning outcomes, and practice organizations commonly give great feedback regarding the work placements. Nevertheless, major challenges were revealed during the implementation of the undergraduate program regarding form of study, employability of graduates, and complexity of teaching and learning HP in an undergraduate program. These measures taken of the undergraduate program in HP at the ZHAW in Switzerland can surely be relevant and transferable to other cultural contexts conducting an undergraduate program in HP.

Special attention is currently drawn to the form of study program and an adequate didactic methodology to teach the complexity of HP, which will allow students to form their professional identity in HP. To ensure more self-directed learning opportunities in the future, we plan to adapt the program to a more flexible form as described section “Form of Study”. Restrictions following the COVID-19 pandemic opened up ways of flexible and more online-based learning. By extending the concept of flipped classrooms, where students individually gain knowledge prior to the in-class lecture either by reading texts, watching eCasts, or the like, we promote students’ empowerment and self-directed learning. This implies an understanding of the teaching and learning setting, where the lecturer is seen as coach and moderator rather than as a mediator of knowledge. Enabling more options for specialization within the undergraduate program will ease students’ successful transfer to the labor market as suggested in the literature.

Ensuring a supportive learning environment for HP, we further advocate raising publicity and quality assurance in practice and policy of HP in Switzerland and internationally. We therefore promote the exchange and discussions between students, graduates, and practice on social media platforms, meetings at conferences, engaging in professional associations related to HP, and the establishment of an Alumni network. Within these networks, we plan to ease the foundation of a professional association in HP in Switzerland. Furthermore, we want to strengthen the international profile of our undergraduate program by publishing on our experiences with the teaching-learning setting in HP, by extending the collaboration with international study programs in HP and therefore strengthening HP in Switzerland and internationally.

Table 3.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 3.2 Authors' reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	Referring to the Ottawa Charter, HP focusing on socioeconomic and socio-environmental determinants of health on a community level has the potential to support the most vulnerable groups in society. Health is produced in the environment where people live and work, which leads to the fact that health can be promoted in these environments via multiple stakeholders, e.g., families, schools, workplaces, health professionals, etc. HP practitioners are specialized in supporting these environments advocating for health, mediating between stakeholders, and enabling health in the communities reflecting on participation and reducing health inequity in the community. HP is seen as the field of action of PH with greatest practical relevance and therefore the need for special competencies in HP. HP focuses on promoting protective factors for health and creating supportive environments, whereas prevention focuses on reducing risk factors for health. Both concepts aim for maximum health gain and are understood as complementary fields of action within PH
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	The undergraduate program in HP started in 2016 and is the first undergraduate in HP in Switzerland yet. Up to then only 1/3 of professionals in HP were specifically trained in HP, instead are mostly lateral entrants to the field of action. Educational training was only possible via continuing education programs usually containing 10–60 ECTS. HP in Switzerland is quite well institutionalized, led by the national foundation "Health Promotion Switzerland" and the Federal Office for Public Health and therefore is also anchored in health politics. Overall, the implementation of the undergraduate program in HP at the ZHAW can be seen as a milestone in the professionalization of HP in Switzerland and in the long term promotes quality assurance in practice, research, and policy of HP. The program (180 ECTS) is provided as a full-time (3 years) or part-time (5 years) program to a maximum of 66 students. In 2021, the third cohort will graduate
Which theories and methodologies are used in the teaching-learning process?	The outlined learning outcomes are based on the CompHP to ensure international transferability of HP competencies. The focus is on a threefold methodological approach, consisting of (1) practical training, (2) skills training (research, project management, and communication), and (3) interprofessional training

(continued)

Table 3.2 (continued)

Questions	Take-home messages
What kind of forms of assessment are applied, results achieved, and challenges faced?	To comply with constructive alignment, different modules focus on different formats of assessments to reach the learning outcomes/competencies of the undergraduate program. As collaboration is an important competence in HP, many assessments must be passed in group work. Depending on the subject, different assessments are applied in different terms of the program, e.g., oral presentations, written term papers, epidemiological factsheets, and applying research methods. At the same time, individual work is produced, e.g., reflection reports, written exams, and the bachelor thesis, which is usually written in relation to the work placements. Experiences with 5 years of program implementation have revealed challenges, e.g., adapting the form of study to the current trend of flexible education, enabling more self-directed learning opportunities, and promoting better employability of the graduates. By providing a supportive learning environment for HP, the program contributes to publicity and quality assurance in practice and policy of HP in Switzerland and internationally. For continuous evaluation, a research project was set up at the beginning of the undergraduate program in 2016 which investigates the professional identity formation of the future HP practitioners. Online surveys and focus groups reveal great evaluation results to continuously adapt the undergraduate program
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The professional competencies and learning outcomes of the undergraduate program in HP are generally based on the CompHP to comply with international standards of HP. The professional roles referring to HP are described in seven roles are named (1) experts, (2) communicators, (3) collaborators, (4) leaders, (5) health advocates, (6) scholars, and (7) professionals. Generally, the teaching-learning setting is supposed to stick to the principles of HP. This means the lecturers are keen on creating a supportive environment for students and enable participation and empowerment in the courses and the program where applicable. Moreover, a special interest is to promote social equity and therefore promote students with greater challenges, e.g., mental health issues or reconciliation of family and studies
What others could learn with your experience? What is localized and what is "generalizable"?	Five years after the implementation of the first undergraduate program in HP in Switzerland have revealed both success and challenge. The program was designed with two forms of study, enabling students to study full-time or part-time. Current trends toward flexible education are planned to be adapted, as well as enabling more self-directed learning and opportunities for individual specialization. Measures in this direction will further raise the employability of program graduates and contribute to promoting and embedding the complexity of HP as a professional profile in policy and society. These measures taken can surely be relevant and transferable to other cultural contexts conducting an undergraduate program in HP

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Chapter 4
The First Francophone Africa Online Master Degree Course in Health Promotion: Key Features and Perspectives

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Introduction

The African region of the World Health Organization (WHO), after the adoption of the first health promotion strategy in 2001, followed by implementation guidelines in 2002, found in 2011 that member countries had made little progress in adopting and implementing health promotion (WHO, 2011). This finding confirmed the results of a study conducted in the region in 2005, which is particularly acute in the French-speaking part of the region (Gnahoui-David et al., 2005). In a mini review focusing on the HP status in the African region, Houeto and Valentini (2014) showed that HP is not well-known, and this is more crucial in the Francophone part of the region. They stressed that there still is room for HP development in the region, and the key approach is capacity building for the formation of a critical mass of professionals mastering the concept. While we are approaching the deadline of 2030 for the SDGs, it is crucial to put forth interventions that could contribute to this end in the region (Houeto & Sambieni, 2016). It is based on this goal that a team of professionals through the International Francophone Network for HP (REFIPS) chose to set up an international online Master degree course in French in collaboration with academic institutions in the developed world.

Description of the Context

Much progress has been made in the field of health with many benefits for the well-being of the populations. However, the failure of primary health care (WHO, 1978, 2008b) and the situation of non-achievement of the Millennium Development Goals (MDGs) (UNECA, AU, ADB and UNDP, 2015) by the vast majority of developing countries in general and those of the African region in particular are a sign of a certain need to strengthen the health systems (Sharp & Milium, 2015).

From the perspective of the disease focus, countries in the African region have failed to implement primary health care (PHC) and the MDGs, for not addressing the root causes of health and well-being (UNECA, AU, ADB and UNDP, 2015; WHO, 2008b, 2014a). The SDGs are doomed to the same fate if health systems do not change their strategy (Frenk et al., 2010).

The African region has made significant progress in the adoption of health promotion by Member States since 2001 (WHO, 2001, 2002). However, in addition to the political will of Member States, little progress has been made at the individual state level. This was confirmed by the Ouagadougou Declaration of April 2008 for the revitalization of the primary health-care strategy (PHC) (WHO, 2008a) and the WHO progress report on the implementation of the regional health promotion strategy of July 2011 (WHO, 2011). One of the reasons for this situation is undoubtedly the lack of competent human resources in health promotion, which is particularly prominent in the Francophone region (Houeto & Valentini, 2014). While it is possible to find training institutions focusing on health promotion in the Anglophone

part of the region, there is no one in the Francophone part offering this kind of training (Houeto & Sambieni, 2016). Africa as a region has in itself some cultural particularities which cannot be ignored, and offering health promotion training in each particular context – Anglophone, Francophone – will have an added value that contributes to better address the health issues in the region. It is in this perspective that the University of Parakou, through its School of Public Health, initiated to the African countries a Master's degree program in health promotion – the first of its kind in the Francophone region – for the optimization of the performance of public health strategies and policies (Houeto & Sambieni, 2016).

Health promotion is not well-known in Francophone Africa. Understandings of health are very much set within the biomedical vision (Dever, 1976). But it seems that with the COVID-19 pandemic which has, in a particular way, tested the best organized health systems in even the most developed countries, some health professionals are changing their perspectives on health and the health issues. Our program, in taking advantage of this situation as a "game changer," puts an emphasis on the necessity for the health systems in the region to adopt an approach that looks at the individual before the disease onset, instead of primarily focusing on the disease and giving less consideration to the people's living conditions (Frenk et al., 2010). This is something we noticed gained the attention of many applicants to our program.

In order to make this program different and radical, collaboration was sought with internationally recognized experts in the field, particularly those from the Université du Québec à Montréal (UQAM) and the University of Geneva (UniGe) and also support from the International Francophone Network for Health Promotion (REFIPS) which is the Francophone branch of the International Union of Health Promotion and Education (IUHPE). REFIPS was actively involved in looking for a complementary funding that led to the collaboration with the Francophone Universities Agency (AUF).

The Program

Aims and Objectives

This program aims to produce African experts in health promotion trained in their own environment in order for them to better understand the particularities that are specific to it and that contribute to the development of health and well-being of populations on a continent that needs it so much. The training is organized taking into account the specific needs of each participant through a personalized structuring in order to allow everyone to acquire the necessary skills in health promotion to improve their practices. More specifically, the online Master's degree in Health Promotion aims to provide the learner with the necessary skills to:

1. Organize health projects and programs on the basis of action on the social determinants of health
2. Develop the skills of a community development catalyst in their own context
3. Build a necessary and indispensable partnership with communities and other health and non-health sectors
4. Plan activities with a view to empowering communities in order to reduce social inequalities in health and ensure sustainability
5. Evaluate the processes as well as the results of interventions from a community empowerment perspective
6. Carry out permanent advocacy to rallying all stakeholders to health action on the basis of the social determinants of health
7. Influence the reorganization of the health system in the direction of action on the social determinants of health and the achievement of the objectives of health and well-being of the populations

The Target Audience

This program is intended for all persons wishing to contribute to the improvement of the health and well-being of populations and primarily for:

- Medical doctors, dentists, pharmacists, medical assistants,
- Sociologists and medical anthropologists
- Psychologists
- Engineers (biomedical analysis, biochemistry, chemistry, medical imaging)
- Agricultural engineers
- Senior technicians (baccalaureate + higher education) in nursing and obstetrics, public health, hygiene and sanitation, environment, urban planning, education science, nutritionists, dieticians, university-level development professionals corresponding to the profiles of socio-anthropologists, communication specialists, and all other social science fields

Applicants must have an undergraduate degree in any of the abovementioned fields with 2 years of professional experience.

Application includes the following documents: a letter of application addressed to the Director of ENATSE; a curriculum vitae of the applicant; legalized copies of the applicant's university diplomas; a birth certificate of the applicant; three letters of reference from the applicant's supervisors or former lecturer; a letter of motivation from the applicant not exceeding two pages; transcripts of grades from the previous cycle; a legalized copy of the certificate of nationality; an ID photo of the applicant; and a certificate of competence in the English language issued by an accredited center.

Applications were to be submitted on the AUF platform, https://foad-mooc.auf.org/-Master-M1-M2-en-promotion-de-la-.html. The flyer of the course proposed addresses of persons to contact when one is in need of more detailed information.

Table 4.1 Distribution per age groups, occupation, and professional experience of applicants ($N = 218$)

Variables	Frequency	Percentage
Age groups		
[20–25]	9	4.13
[25–30]	51	23.39
[30–35]	49	22.48
[35–40]	55	25.23
[40–50]	47	21.56
≥50	7	3.21
Occupation		
Civil servant	61	27.98
NGO employee	58	26.61
Private sector employee	36	16.51
Students	18	8.26
Lecturer	10	4.59
Unemployed	8	3.67
Others	27	12.38
Professional experience		
1 year	16	7.35
1–3 years	45	20.64
3–5 years	46	21.10
5–10 years	67	30.73
More than 10 years	44	20.18

Characteristics of the Participants

At the end of the recruitment process of the first cohort (2020–2021), the total number of applicants were 218 with 157 males (72.02%) and 61 females (27.98%). Table 4.1 is related to the distribution per age groups, occupation, and professional experience of applicants, and Table 4.2 is related to the distribution per countries and regions of applicants. The selection procedure permitted 127 applicants for the course. Finally, 97 effectively confirmed their application. Tables 4.3, 4.4, and 4.5 show the characteristics of those 97 students enrolled for the course after the selection procedure. The AUF gave four scholarships amounting to half of the school fees to one female from Cameroon and three males from Benin, Côte d'Ivoire, and Togo.

A specific focus on the professional profiles of students involved in the course shows an important diversity from health professionals such as medical doctors, nurses, and midwives to managers, hygiene and sanitation specialists, civil society organization specialists, etc. (see Table 4.4).

Table 4.2 Distribution per countries and regions of applicants ($N = 218$)

#	Regions	Countries	Frequency	Percentage
1	West Africa	Benin	55	25.22
2		Burkina Faso	17	7.80
3		Côte d'Ivoire	12	5.50
4		Guinea	10	4.59
5		Mali	12	5.50
6		Niger	1	0.46
7		Senegal	11	5.05
8		Togo	7	3.21
		Sub-total	*125*	*57.34*
9	Central Africa and The Great Lakes	Burundi	8	3.67
10		Cameroon	20	9.17
11		Chad	9	4.12
12		Congo	5	2.29
13		DRC	17	7.80
14		Equatorial Guinea	1	0.46
15		Gabon	1	0.46
16		Rwanda	2	0.92
		Subtotal	*63*	*28.90*
17	Eastern Africa	Djibouti	2	0.92
18	Maghreb	Algeria	2	0.92
19		Morocco	2	0.92
20		Tunisia	2	0.92
		Subtotal	*6*	*2.75*
21	Indian Ocean	Comoros	1	0.46
22	Caribbean	Haiti	17	7.80
23	Americas	USA	1	0.46
24	Western Europe	Belgium	1	0.46
25		France	2	0.92
		Subtotal	*3*	*1.38*
Total			*218*	*100*

DRC Democratic Republic of Congo, *USA* United States

Courses Involved

The Master's degree in Health Promotion covers the traditional areas of public health (e.g., Biostatistics, Epidemiology) with a specific focus on, among others, history of health promotion; social determinants of health (SDH); health inequalities; principles and values of health promotion; health in all policies (HiAP); health impact assessment (HIA); settings approaches (workplaces and markets, schools/universities, cities and towns, hospitals); health promotion and disease control (communicable and noncommunicable); community-based participatory action research (CBPR); health promotion and community development; health promotion policy and planning; risk communication and community engagement (RCCE);

Table 4.3 Distribution per age groups, occupation, and professional experience of students enrolled after the selection procedure ($N = 97$)

Variables	Frequency	Percentage
Age groups		
[20–25]	3	3.10
[25–30]	18	18.56
[30–35]	26	26.80
[35–40]	20	20.62
[40–50]	28	28.87
≥50	2	2.05
Occupation		
Civil servant	35	36.09
NGO employee	27	27.84
Private sector employee	28	28.86
Students	1	1.03
Lecturer	2	2.06
Unemployed	4	4.12
Professional experience		
1 year	8	8.25
1–3 years	8	8.25
3–5 years	19	19.59
5–10 years	36	37.11
More than 10 years	26	26.80

Table 4.4 Distribution of students enrolled after the selection procedure per professional profiles ($N = 97$)

Variables	Frequency	Percentage
Medical doctors	46	47.42
Nurses	10	10.31
Midwives	5	5.16
Lab technician	4	4.12
Social worker	4	4.12
Pharmacists	3	3.10
Managers	3	3.10
Communicators	3	3.10
Sociologists	3	3.10
X-ray technician	3	3.10
Public health technician	3	3.10
Environmental health technician	2	2.06
Lecturers-medical doctors	2	2.06
Librarian	1	1.03
Pharmacy assistant	1	1.03
Psychologist	1	1.03
Physiotherapist	1	1.03
Dentist	1	1.03

Table 4.5 Distribution of students enrolled after the selection procedure per countries and regions

#	Regions	Countries	Frequency	Percentage
1	West Africa	Benin	41	42.27
2		Burkina Faso	7	7.22
3		Côte d'Ivoire	3	3.09
4		Guinea	7	7.22
5		Mali	4	4.12
6		Senegal	3	3.09
7		Togo	1	1.03
		Subtotal	*66*	*68.04*
8	Central Africa and The Great Lakes	Burundi	5	5.16
9		Cameroon	8	8.25
10		Chad	2	2.06
11		Congo	2	2.06
12		DRC	3	3.09
13		Gabon	1	1.03
		Subtotal	*21*	*21.65*
14	Eastern Africa	Djibouti	1	1.03
15	Indian Ocean	Comoros	1	1.03
16	Caribbean	Haiti	7	7.22
17	Americas	USA	1	1.03
Total			*97*	*100*

DRC Democratic Republic of Congo, *USA* United States

evaluation in health promotion; and mental health promotion. Table 4.6 shows the detail of the courses involved.

Theories and Methodologies Used in the Teaching-Learning Process

In order to be in line with the Galway Consensus Statement (Allegrante et al., 2009), we organized several meetings among the partners, both pedagogic and technical, in order to deliver a program that really fits in the core competencies of health promotion and also be well organized online (as it is our first experience). The techno-pedagogue among us plays an important role through an agenda of a series of two webinars for lecturers on how to prepare and deliver courses online. Also, AUF personnel, in charge of the technical aspect of e-learning, organized webinars with lecturers and the students initiating them with the use of the created platform before we could start the courses.

The training, centered on the learner, aims at the acquisition of tools, techniques, and methods of health promotion and their concrete and effective use in practical situations. The teaching is given according to the interrogative and discovery method, with alternation of the following learning techniques: lectures, interactive

Table 4.6 Courses involved in the online Master's Program in Health Promotion, University of Parakou

Codes	Courses	Th.Crs	TD/TP	TPA	CTT	CECT
Year 1, Semester 1						
HPS 0101	Fundamentals of Health Promotion					
HPS 0101.1	Foundations of Public Health	36 (4)	20	40	100	6
HPS 0101.2	History of Health Promotion	18 (3)	10	22	50	
SOC 0101	Behavioral Foundations					
SOC 0101.1	Socio-anthropology and Health	27 (3)	20	28	75	6
SOC 0101.2	Models of Health and Theories of Behavior Change	27 (3)	20	28	75	
BST 0101	Bio-statistics	36 (4)	34	30	100	4
EPI 0101	Epidemiological Studies	30 (4)	30	40	100	4
AAS 0101	Action on the Social Determinants of Health 1					
AAS 0101.1	Health Inequalities	27 (3)	20	28	75	6
AAS 0101.2	Health Service Organization	27 (3)	20	28	75	
IFA 0101	Applied Computer Science					
IFA 0101.1	Computerized Management of Bibliographic References	18 (3)	15	17	50	4
IFA 0101.2	Data Processing and Analysis Software (Epi-Info, Epi-Data, R)	18 (3)	15	17	50	
Total						*30*
Year 1, Semester 2						
MSS 0102	Health Planning					
MSS 0102.1	Health Policy and Health Development Plans	20 (2)	12	20	50	5
MSS 0102.2	Health Services Management	27 (4)	20	28	75	
RPS 0102	Research for Health	26 (4)	10	60	96	4
DSS 0102	Déterminants sociaux de la santé	38 (4)	12	75	125	5
AAS 0102	Action on the Social Determinants of Health 2					

(continued)

Table 4.6 (continued)

Codes	Courses	Th.Crs	TD/TP	TPA	CTT	CECT
AAS 0102.1 *AAS 0102.2* *AAS 0102.3*	Health in All Policies (HiAP)	18 (3)	10	22	50	6
	Environment and Health	13 (3)	6	31	50	
	Health Impact Assessment	13 (3)	6	31	50	
EPS 0102	Evaluation					
EPS 0102.1 *EPS 0102.2*	Community-Based Participatory Action Research (CBPR)	18 (3)	8	49	75	5
	Evaluation in Health Promotion	19 (3)	11	20	50	
STP 0102	Internship 1	06 (3)	13	32	51	2
ANG 0102	English Language	27 (3)	22	26	75	3
Total						*30*
Year 2, Semester 3						
SAP 0103	Settings Approaches	13 (3)	6	31	50	2
CEC 0103	Risk Communication & Community Engagement (RCCE)	19 (4)	0	32	51	4
MPS 0103	Health Promotion Intervention Methods					
MPS 0103.1 *MPS 0103.2*	Methods and Strategies in Health Promotion	19 (3)	0	32	51	6
	Principles and Values of health promotion	20 (4)	18	62	100	
COM 0103	Health Promotion and Community Development	20 (4)	18	62	100	4
PPS 0103	Health Promotion Policy and Planning	20 (4)	18	62	100	4
NUT0103	Physical condition					
NUT0103.1 *NUT0103.2*	Nutrition and Health	18 (3)	0	36	54	3
	Physical Activity and Health	9 (2)	3	16	28	
EPM 0103	Protocol					
EPM 0103.1 *EPM 0103.2*	Internship 2	13 (3)	6	31	50	6
	Elaboration de protocole pour mémoire	17 (4)	22	61	100	
ETH 0103	Ethics in Health Promotion	9 (2)	5	11	25	1

(continued)

Codes	Courses	Th.Crs	TD/TP	TPA	CTT	CECT
Total						*30*
Year 2, Semester 4						
MNT 0104	Noncommunicable diseases					
MNT 0104.1	Mental Health Promotion	18 (3)	0	32	50	5
MNT 0104.2	Health Promotion and Control of Noncommunicable Diseases	22 (3)	6	48	76	
SAV 0104	In-depth Aspect of Setting Approaches 1					
SAV 0104.1	Health Promoting Schools	18 (3)	2	30	50	4
SAV 0104.2	Healthy Cities	18 (3)	4	30	52	
SAT 0104	In-depth Aspect of Setting Approaches 2					
SAT 0104.3	Health Promoting Hospitals	18 (3)	4	30	52	4
SAT 0104.4	Health Promotion in Workplaces and Markets	18 (3)	2	30	50	
PMT 0104	Health Promotion and Communicable Disease Control	22 (3)	6	48	76	3
CDM 0104	Research Methodology					
CDM 0104.1	Qualitative Research	6 (3)	20	30	50	5
CDM 0104.2	Data Collection (protocol validation)	12 (3)	15	28	50	
CDM 0104.3	Medical Writing	9 (2)	5	11	25	
ARM 0104	Data Analysis	12 (4)	34	79	125	4
DSM 0104	Dissemination and Defense of the Thesis	22 (3)	0	48	75	3
LEM 0104	Leadership and Management	18 (3)	6	26	50	2
Total						*30*

Th.Crs Theoretical courses, *TP* Hands-on work, *CTT* Total workload, *TPA* Learner's personal work, *CECT* Capitalizable and transferable assessment credit, *(…)* minimum number of synchronous sessions per course

exercises, simulations, case studies, role plays, animated pedagogical resources, seminars, field activities, individual/group work (see example of group work in Box 4.1, individual exercises in Box 4.2). Students also had an internship in a "company." In regard to the internship, we valued more settings like municipalities for they are more required in the production of health of populations (WHO, 2016). At the end of the process, a dissertation will be prepared by each student and publicly presented online before a jury.

Box 4.1 Example of Group Work

Students, in groups of maximum five members, were to translate into French each chapter of two books of Michael Marmot. The objective is to be familiar with discussions related to health inequalities around the world authored by a health promotion expert and former Director of the WHO commission on Social Determinants of Health.

Marmot M (2015). The Health Gap: The challenge of an unequal world. Bloomsbury, London, UK.

- *G1:* Introduction (p1–21)
- *G2:* Chap. 1: The Organization of Misery (p22–48)
- *G3:* Chap. 2: Whose Responsibility? (p49–76)
- *G4:* Chap. 3: Fair Society, Healthy Lives (p77–110)
- *G5:* Chap. 4: Equity from the Start (p111–142)
- *G6:* Chap. 5: Education and Empowerment (p143–169)
- *G7:* Chap. 6: Working to live (p170–198)
- *G8:* Chap. 7: Do Not Go Gentle (p199–227)
- *G9:* Chap. 8: Building Resilient Communities (p228–255)
- *G10:* Chap. 9: Fair Societies (p256–289)
- *G11:* Chap. 10: Living Fairly in the World (p290–326)
- *G12:* Chap. 11: The Organisation of Hope (p227–346)

Marmot M (2004). Status syndrome: How your place on the social gradient directly affects your health. Bloomsbury, London, UK.

- *G13:* Introduction (p1–12)
- *G14:* Chap. 1: Some Are More Equal than Others (p13–36)
- *G15:* Chap. 2: Men and Women Behaving Badly? (p37–61)
- *G16:* Chap. 3: Poverty Enriched (p62–82)
- *G17:* Chap. 4: Relatively Speaking (p83–105)
- *G18:* Chap. 5: Who's in Charge? (p106–141)
- *G19:* Chap. 6: Home Alone (p142–168)
- *G20:* Chap. 7: Trusting Together (p169–195)
- *G21:* Chap. 8: The Missing Men of Russia (p196–221)
- *G22:* Chap. 9: The Travails of the Fathers … and Mothers (p222–246)
- *G23:* Chap. 10: The Moral Imperative and the Bottom Line (p247–266)

Box 4.2 Examples of Individual Exercise

- Explain the common thread between the Lalonde Report, the PHC Declaration, Health for All 2000, the MDGs, and the SDGs.
- List the global health promotion conferences up to 2016 and their respective themes.
- Show the importance of the three main axes of the report of the WHO Commission on Social Determinants of Health (SDH) in rallying the non-health sectors in achieving the objectives of improving the health of populations.
- Describe the concept of the *social gradient*, and show why it is important in health programs and projects to achieve better outcomes.
- Describe the relationship between the social determinants of health and the reduction of social inequalities in health.
- Explain, in the context of the implementation of a project, the mechanisms for reducing social inequalities in health.
- Analyze the Mexico 2000 Declaration on Health Equity.
- Analyze the 2012 WHA resolution WHA65.8 on social inequalities in health.

Duration and Frequency of Activities

The duration of courses is according to their specific credit. Table 4.6 shows the number of synchronous sessions (…) and the allocated time for each course from the theoretical sessions to individual student's work. The internship duration is for a minimum of 6 weeks.

Forms of Assessment

The assessment process is continuous with a final exam. Each teaching unit is evaluated and credited when the requirements for evaluation are met. Individual and group work are credited also and count for 20% and 30%, respectively. Students also have the opportunity to fill a form just at the end of each course in order to assess the lecture process by the lecturer. We are currently working on the results in order to give feedback to the lecturers before they start the second year of the training. Our commitment to this is that we do it on a regular basis next year and get back to each lecturer closer to the period he/she finishes the lecture.

Results Achieved and Challenges Faced

When considering the students' participation in the synchronous sessions, it varies from a minimum of 71 to 93 from the beginning in October 2020 to March 2021.

We undertook an evaluation with the students in March and came up with the following main impressions and issues for the period covered by the program:

- The distance learning format suits them.
- The level is high, and they are satisfied with the training and the quality of the lecturers.
- They realize the lack of professionals in the field of health promotion at the country level.
- Their motivation is high to do their best and to participate in changes in their countries to improve health and provide the community with the means and conditions to improve their health.
- They believe that what is important is to focus on the social determinants of health and social inequalities in health.
- They appreciate the multicultural experience that the training offers, with students coming from all over Africa.

Analysis

The burden of disease in the African region has something to do with the lack of professionals knowing fully how to address the SDHs as has been recognized by several authors (Houéto & Valentini, 2014; Houeto & Sambieni, 2016; Nyamwaya, 2003; WHO, 2012). We are asking the same question as Gebbie et al. (2003) put it, "who will keep (Africa) healthy?" It is important to provide the region with professionals who are aware of the importance of the approach that maintains and improves the health of populations and which is based on the principles of social justice, attention to human rights and equity, and evidence-informed policy and practice and that addresses the underlying determinants of health (UN Platform on Social Determinants of Health (ILO, UNDP, UNFPA, UNICEF, WHO, UNAIDS), 2012). Such an approach places health promotion as the central tenet of all health initiatives (CAPH, 2016).

According to Houéto and Valentini (2014), many professionals in the francophone region use the term health promotion without its values and principles as stipulated by the WHO (1998). That is one of the reasons why we decided to implement a genuine health promotion course based on its values and principles such as a social-ecological model of health that takes into account the cultural, economic, and social determinants of health; a commitment to equity, civil society, and social justice; a respect for cultural diversity and sensitivity; a dedication to sustainable development; and a participatory approach to engaging the population in identifying needs, setting priorities, and planning, implementing, and evaluating the

practical and feasible health promotion solutions to address needs (Allegrante et al., 2009; Gebbie et al., 2003; WHO, 1998). For instance, we have a close collaboration with Sir Michael Marmot in translating two of his books, *The Health Gap* and *The Status Syndrome*, into French in order to allow our students to get familiar with some important materials that already exist in English.

The curriculum we developed (see Table 4.6), as an international team of experts in health promotion, considered the Galway Consensus Statement in defining the competencies required to engage in health promotion practice which include (Allegrante et al., 2009):

1. *Catalyzing change* – Enabling change and empowering individuals and communities to improve their health.
2. *Leadership* – Providing strategic direction and opportunities for participation in developing healthy public policy, mobilizing and managing resources for health promotion, and building capacity.
3. *Assessment* – Conducting assessment of needs and assets in communities and systems that leads to the identification and analysis of the behavioral, cultural, social, environmental, and organizational determinants that promote or compromise health.
4. *Planning* – Developing measurable goals and objectives in response to assessment of needs and assets and identifying strategies that are based on knowledge derived from theory, evidence, and practice.
5. *Implementation* – Carrying out effective and efficient, culturally sensitive, and ethical strategies to ensure the greatest possible improvements in health, including management of human and material resources.
6. *Evaluation* – Determining the reach, effectiveness, and impact of health promotion programs and policies. This includes utilizing appropriate evaluation and research methods to support program improvements, sustainability, and dissemination.
7. *Advocacy* – Advocating with and on behalf of individuals and communities to improve their health and well-being and building their capacity for undertaking actions that can both improve health and strengthen community assets.
8. *Partnerships* – Working collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion programs and policies.

In order to assure the quality of this program, in accordance with AUF and all the three collaborating Universities, we developed quality assurance mechanisms and some materials adapted from experiences elsewhere to be used on a regular basis. For instance, the culture here in the region is not to evaluate lecturers after they have delivered their courses. We rephrased some terms and changed some of them in order for those involved in our program to accept that evaluation from students after their lectures. In discussing with the lecturers, it was important to explain the crucial role that plays this evaluation by students for it gives the opportunity to, for instance, reframe the course by integrating aspects that can make it clearer for students' understanding.

The African region has many possibilities to improve the health of its population, and we are confident in the fact that a critical mass of professionals trained with the ecological model of health which allows to develop interventions with the ecological view and approach (Dever, 1976) will help achieve the international goals ahead, e.g., the SDGs (UN Platform on Social Determinants of Health (ILO, UNDP, UNFPA, UNICEF, WHO, UNAIDS), 2012). Actually, the distance learning format is very crucial in helping with the enrolment of many health professionals who do not necessarily need to leave their job before being enrolled in this program. Because of their experiences on the ground, many health professionals can realize through this program a means to address most of the challenges they are facing, and this prompts them to apply. This is particularly obvious when considering the profile of the applicants who are in the majority of medical doctors. According to them, this program will help them get expected results in the improvement of the health of the populations for which they are working because it is clearer for them now that health cannot be improved by the health sector alone but in strong collaboration with the other non-health sectors in order to address the SDHs.

The Potential for Applicability of the Experience in Other Contexts

The lesson learnt from this program at this stage is that partnership is key in building a strong agenda like this. We benefited a lot from the expertise of our partners, and we must also say that another important issue is actually the confidence among each other that we built from a long individual collaboration in working together. With the importance to be given then to collaboration among institutions as we managed to set up in this program, universities, health promotion professional association, and technical distance learning institution, we are on the way to achieve consistent results. It is to say that anyone who tries to build such a partnership is about to achieve similar results.

Conclusion

The situation we are facing in the African region in regard to the health situation of the population is clearly manageable in addressing the SDHs. In order to do so, we need a critical mass of professionals mastering what HP is all about through its values and principles with the international standards. We are committed to add our little contribution to its development in order that countries could count on competent human resources that help improve the health of the populations.

Table 4.7 brings our reflection on the six triggering questions suggested by the Editors.

Table 4.7 Authors´ reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	Our vision about HP is that it contributes to address the SDHs, reduces health inequalities (WHO, 2014b) with an important mechanism which consists to "make all sector a health sector" (WHO, 2008c), and considers community's involvement in interventions that aim to improve their health and also the process as well as the impact of the implementation of those interventions
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	Health promotion is not well-known in the context we are implementing this program We are still facing many challenges because of that situation of not knowing health in other ways than the biomedical vision. We are running this program with our own resources with strong support from our partners. If we were to rely on the process that is ongoing in our institution, we would not have continued the program at this stage. But it is encouraging to notice the commitment of the students and the trust they have developed in the coordinator of the program during the short time of period we spent together in implementing this program
Which theories and methodologies are used in the teaching-learning process?	The training, centered on the learner, aims at the acquisition of tools, techniques, and methods of health promotion and their concrete and effective use in practical situations The teaching is given according to the interrogative and discovery method, with alternation of the following learning techniques: lectures, interactive exercises, simulations, case studies, role plays, animated pedagogical resources, seminars, field activities, individual/group work, internship in a "company." In regard to the internship, we valued more settings like municipalities for they are more required in the production of health of populations (WHO, 2016)
What kind of forms of assessment are applied, results achieved, and challenges faced?	The course's evaluation process is continuous with a final exam. Each teaching unit is evaluated and credited when the requirements for evaluation are met. Individual and group works are credited also and count for 20% and 30%, respectively Students also have the opportunity to fill a form just at the end of each course in order to assess the lecture process by the lecturer. We are currently working on the results in order to give feedback to the lecturers before they start the second year of the training. Our commitment to this is that we do it on a regular basis next year and closer to the period each lecturer finishes to lecture Lecturers here are not familiar with the fact that students have to evaluate the implementation of their courses. We had to negotiate and change terms in order to allow the acceptance of that evaluation

(continued)

Table 4.7 (continued)

Questions	Take-home messages
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The Ottawa charter (WHO, 1986) with its strategies and pillars, the values and principles of HP according to WHO (1998), and the Galway Consensus Statement are the foundations of our teaching and learning process. We strongly value HP the way it has been developed by experts in the domain. For instance, we have a close collaboration with Sir Michael Marmot in translating two of his books, *The Health Gap* and *The Status Syndrome*, into French in order to allow our students to get familiar with some important materials that already exist in English
What could others learn with your experience? What is localized and what is "generalizable"?	The lessons learnt from this program at this stage is that partnership is key in building a strong agenda like this. We benefited a lot from the expertise of our partners, and we must also say that another important issue is actually the confidence among each other that we built from a long individual collaboration in working together. With the importance to be given then to collaboration among institutions as we managed to set up in this program, universities, health promotion professional association, and technical distance learning institution, we are on the way to achieve consistent results. It is to say that anyone who tries to build such a partnership is about to achieve similar results

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Chapter 5
Debates, Tensions, and Alternatives in Health Promotion Education from South-North and South-South Cooperation: The Health Promotion and Social Development Master Experience

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Introduction

Three-Pronged Move: An Academic Experience Integrating Knowledge and Experiences in Health Promotion from the Southern and Northern Hemispheres

This chapter covers the genesis and development of the iPROMS, Master's Degree in Health Promotion and Social Development, as well as the learnings gathered from its implementation. This health promotion course has been offered since 2013 in Spanish and online by the Institut de Santé Publique, d'Epidémiologie et de Développement (ISPED) at the Université de Bordeaux, France, and the Faculty of Health Sciences at the Universidad Pública de Navarra (UPNA), Spain.

From the outset, the academic experience that is presented here was shaped as a triangular prism involving faculty members from the UPNA, the ISPED, and a group of Latin American faculty. It was intentionally structured around a democratic and reciprocal exchange between diverse perspectives involving public health and health promotion knowledge and practices in the South and in the North.

The work that informed this chapter took place within the context of the COVID-19 pandemic, a social and health emergency with global but differential impacts that are creating—and aggravating—inequalities and gaps predominantly affecting the most vulnerable social groups. Such a scenario seriously constrains social interactions, currently characterized by the so-called social distancing measures, making even more evident the value of using remote platforms to facilitate academic exchange and collaboration.

This chapter was prepared from a perspective that is interdisciplinary and intercultural and seeks to integrate diverse professional voices and trajectories, resulting in a perspective that reflects the complexity of health promotion field.

This manuscript was written 10 years after the conception of the academic experience described below. Despite the numerous constraints, a constructivist way of

understanding this academic experience was maintained, consequently fueled by greater motivation, creativity, and productivity. Such a particular way of co-production and transmission of knowledge seeks to produce new insights and contributes to the resignification of the teaching of health promotion.

The integrated and critical approach intended to break with the northern hemisphere hegemony in the field of public health and health promotion. This was done by integrating in the Master's Curriculum experiences, knowledge, and references from the Latin American region. This goal has been achieved, according to the evidence provided by the evaluative views of the successive cohorts of the master.

Aimed at training public health and health promotion professionals, the academic proposal is based on a concept of health promotion as an opportunity for social transformation that seeks to surpass rhetoric. Limited not just to a political and technical tool, this strategic movement captures a vision of equity with a focus on human rights and community participation. In other words, a health promotion approach integrating ethics, dialog, and practice. It is also aimed at transforming the complex determinants that shape people's citizenship, quality of life, and health-illness continuum, all this, for all people, without exclusions or discrimination.

The experience began to take shape in 2009 with the launching of two online professional study programs (University Diplomas) in health promotion offered by the ISPED. Firstly, it aimed to generate a basis for knowledge integration and cross-learning among teachers, authorities, and students and, secondly, to strengthen sensitive dynamics and attentive listening to questions and challenges arising from the biographies of students and the teaching team itself, an indelible mark of the way this interdisciplinary and intercontinental team works. The launching of the master's degree in 2013 creatively capitalized on these efforts by reformulating the academic program and working modalities while keeping a virtual learning format.

The first section of this chapter describes the main features of the processes that shaped the Master's experience, in all its possible diversity and uniqueness. The second section explains the key components of the pedagogical proposal, in particular the challenge of pursuing an academic relationship integrating the experience of the southern hemisphere, avoiding hegemonic positions and based on mutual respect and creative dialogue. The last section introduces some of the lessons learned as well as pending challenges and opportunities for scaling up the experience in different scenarios.

There will certainly be new material in the future to continue the conversation and reflection on health promotion academic training, its contents, formats, and relationships. Our understanding of health promotion is such a field of citizen participation and social change, and, finally, on how to take advantage of an experience that is still in progress to make, in an open and transparent way, an argument for continuing dialogues without borders on healthier, fairer, and more equitable societies.

The Process Leading to the Creation of the Master iPROMS

The proposal for the creation of an international training program in health promotion in Spanish and online was born in 2008 at the ISPED as a strategic opening toward the Latino- American region and strongly supported by the presidency of the University of Bordeaux. The development of an academic proposal centered on health promotion also responded to the interest in addressing a field of public health not sufficiently covered in existing international public health training programs.

The key assets for the development and success of the project were (1) the experience and resources developed at the ISPED, with more than 10 years of experience in distance education, in national and international training courses targeting countries in Asia and Africa and (2) the previous experience of delivering a Master's Degree in Health Promotion and Social Development offered in face-to-face modality by the ISPED since the early 2000s. The latter already involved Latin American lecturers participating in various relevant health practitioner networks in the region.

The project also benefited from cooperation and governmental funding from the regions of Aquitaine in France and Navarre and the Basque Country in Spain and aimed toward the creation of an international master's program involving university institutions from the two countries. The team in charge of developing the project also invited and integrated the participation of professionals on both sides of the Atlantic.

This team defined a dual approach to develop the project: (1) to create an original academic proposal, which would ensure dialogue and the transfer of the culture and experience in health promotion of countries from the South and the North and (2) to carry out a long-term vision for a gradual integration of an international training proposal based on the active involvement of a Latin American teaching team into the ISPED and an integration of the ISPED teaching team into the Spanish partner university.

This working modality led to the gradual development and integration of the institutional, conceptual, and human aspects of the academic project (see Fig. 5.1). After several exchanges with Spanish institutions and academic teams in 2010 and 2011, the ISPED established a partnership with the Department of Health Sciences of the Faculty of Health Sciences at the UPNA. A European Master in Health Promotion and Social Development, the Master iPROMS, was subsequently developed. Its accreditation by the corresponding agencies in France (2013) and in Spain (2014) ultimately facilitated the obtainment of an official Degree valid in both countries.

The ISPED team comprised five lecturers based in the Southern Cone of Latin America. This team prepared an academic proposal based, on one hand, on a critical perspective focusing on the political and social dimension of health promotion and, on the other hand, on a pedagogical approach founded on the principles of active distance education techniques.

The contribution of this team started with the creation, in 2009, of previous health promotion study programs implemented by the ISPED and entitled "Principles

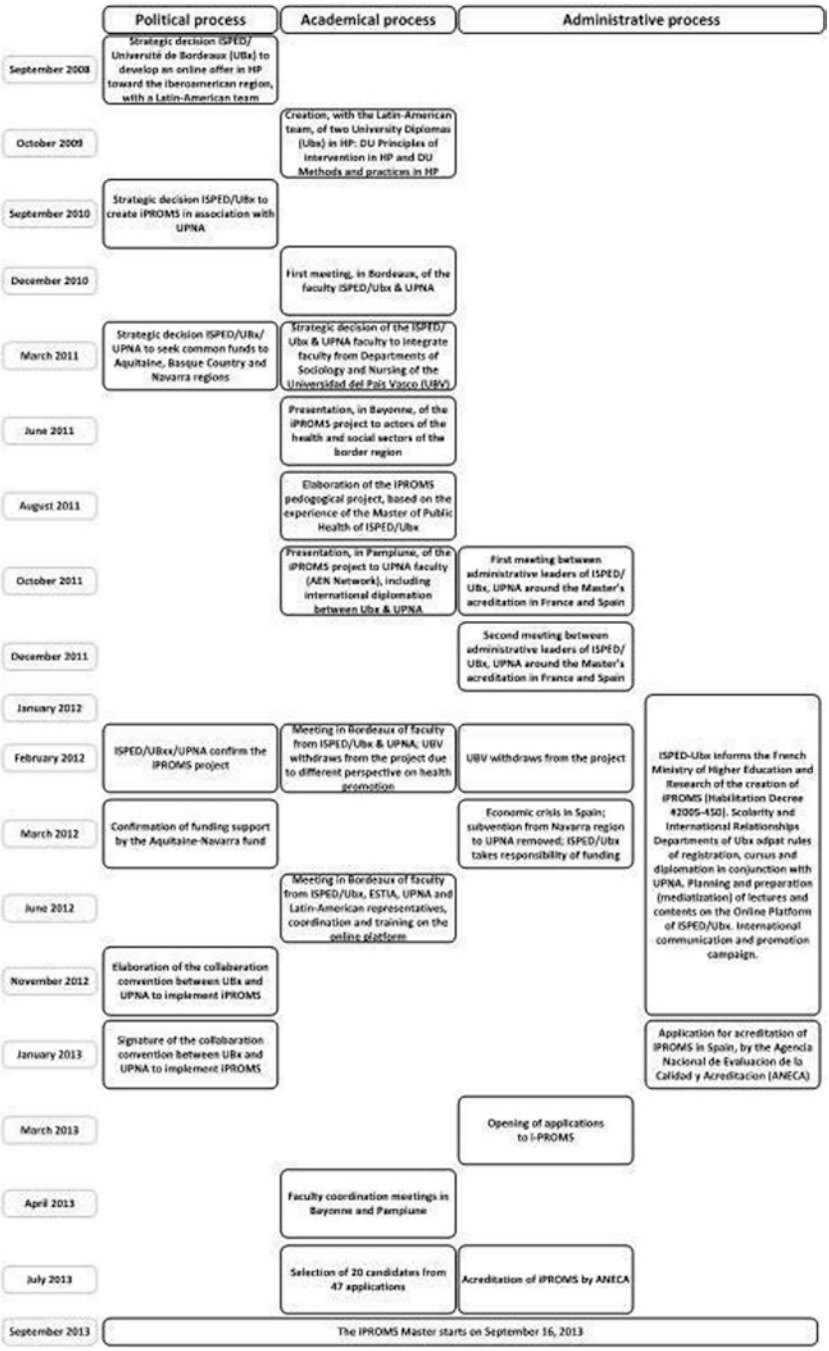

Fig. 5.1 The three processes leading to the creation of the Master iPROMS

of intervention in health promotion" and "Methods and practices in health promotion." The program related to the management of public policies in the specific field of health promotion benefited from the experience of personal and institutional collaborations in Latin America, which contributed to an international and intersectoral perspective that integrated the fields of health, education, and social development. The Latin American team's contribution was formalized through a service contract for a renewable period of 4 years, assigning the courses content copyright to the ISPED and committing the team members to deliver these courses, initially as a part of the aforementioned professional study programs in health promotion and, from 2013, as part of the Master iPROMS.

Currently, the Master iPROMS is advertised as "a postgraduate course jointly proposed by the Public University of Navarra (UPNA) and the University of Bordeaux. Students who have completed the program will have an official double degree from both universities. It is taught in Spanish and via an online teaching platform. The program aims to train competent health professionals in the fields of health promotion and social development with special emphasis on project coordinator profiles and to provide support for the methodological design, formulation, management and evaluation of interventions in prevention and health promotion, in social and community intervention, and in local development projects" (http://www.isped.u-bordeaux.fr/FORMATION/Masters-DUs-DIUs/Masters/Master-2-Promotion-de-la-Sant%C3%A9-en-e-learning-en-espagnol).

Key Factors in the Development of the iPROMS

Thirteen years after the launching of this academic project, a critical analysis of the experience points to four key factors that have facilitated its development:

- A favorable context and strategic orientation for the development of an international training program involving Spain, France, and Latin America by the University of Bordeaux
- A collaborative strategy of national and international institutional alliances, both in terms of its construction modality and breadth of criteria
- An integrated academic proposal that places health promotion in the field of public health and social development
- An innovative pedagogical project that combines classical and constructivist approaches built upon the critical paradigm and led by a teaching team highly committed to its shared vision with an understanding of the issues to be covered and also associated challenges

Structuring Axes of the Pedagogical Proposals: Three Constituent Elements That Define the Training Proposal Can Be Distinguished, Each of Them Integrating Three Structuring Axes

1. A balanced academic collaboration between Europe and Latin America, integrating diverse backgrounds and expertise on both sides of the Atlantic
2. A virtual teaching and learning modality based on a curriculum that is grounded on critical thinking and permeable to emerging challenges and new advances in knowledge
3. A critical orientation toward action and social change

A Balanced Academic Collaboration Between Europe and Latin America: Diverse Disciplinary Backgrounds and Expertise on Both Sides of the Atlantic

The quality of the relational dynamics between the engaged institutions and actors offered the conditions for a fruitful academic collaboration and comprised the first structuring axis. These conditions consolidated an indispensable relationship of dialogue, trust, and respect between the Latin American professors with a perspective forged in the South and the ISPED and the UPNA, as host universities. This relationship represented an intentional deviation from the conventional hegemony of European knowledge over that of the Latin American region. It also challenged stereotypes and stigmatization of populations belonging to other latitudes as a phenomenon affecting not only Latin America citizens and migrants. The shift from *sudacas* to subjects of rights implicit in this collaboration on both sides of the Atlantic Ocean is not a minor issue, resulting in a view from equity and diversity of experiences (pejorative denomination in Spain for those who come from South America).

Diversity permeated the construction of the master's curriculum and became a core component of the program. This takes on new relevance in light of today's complex political scenarios, such as the devastating consequences of forced population displacements, the rise of conservative and fundamentalist movements in the European context, and the discriminatory practices toward migrant populations, a situation that is not alien within the Latin American context. Increasingly conservative administrations and the rise of anti-human rights movements seem to confirm these trends. Within this context, the master's educational proposal represented an affirmation of the value of diversity as a human wealth in all fields, including academia. The design of a relevant curriculum that integrates the diversity of backgrounds and expertise of the teaching team is a second key component of the proposal. The training program developed by the Latin American lecturer's covers,

Table 5.1 A common critical perspective on six curricular modules

Module #	Content
1	Introduction to health promotion
2	Associative strategies and intersectorality in public policies for health promotion
3	Health promotion policies
4	Popular education for health promotion
5	Health promotion in the school environment: the Latin American experience, from ideas to action
6	Health promotion and youth health

Table 5.2 The European modules from UPNA and ISPED

Module #	Content
1	Introduction to public health
2	Prevention of diseases
3	Communication in health
4	Research methods
5	Project planning and management.
6	Evaluation and health promotion programs
7	Individual health promotion
8	From "classical" epidemiology to social and community epidemiology

in six modules (see Table 5.1), the practical, theoretical, and strategic aspects of health promotion. This includes public policies, as well as the programmatic challenges of intersectoral action for health, community approaches, effective local action, and social participation. In addition, other elements of the curriculum address specific fields such as school health or adolescent and youth health, completing the contribution from the Latin American team.

Eight other modules from the European teaching team from the two partner universities complete the program. This second set of modules (see Table 5.2) incorporates the basic principles and foundations of research in public health, communication, and preventive interventions, as well as other specific modules on methods and tools for the design, implementation, and evaluation of public health and health promotion interventions, in this case, from the European perspective.

This curriculum adopts an interdisciplinary approach to health promotion. This is reflected both in the background of the teaching team and enrolled students, presenting very diverse educational profiles and professional careers related to life sciences, health, public health, and social sciences. The educational environment proposes a balance of knowledge and power, avoiding possible "imperialist views" between different disciplines. Particularly noteworthy and interesting is the relationship between social sciences and health sciences, between the biomedical and the social model of health. Such a friendly and constructive dialogue has also been

reflected in the exchanges and cross-learning dynamics established between the teaching team and the students.

Another key aspect is the translation of experiences generated in the Latin American region into the master's contents, references, and authors including the critical reflection process on the complexity of HP in specific contexts. This dimension is closely related to the specific profile of the master's audience, mainly professionals with varying degrees of work experience and previous training in health and health promotion.

This critical dialogue between the experiences of the South and the North can be seen in the resonance of the curricular contents among these professionals. This is particularly evident for those from Europe, who are inspired by and apply or adapt the approaches, methods, and tools specific to the Latin American context to their course assignments and their master's thesis having incorporated community-based and popular education approaches inspired from the Latin America tradition: assignments targeting pregnant mothers or gypsy communities in Toulouse, migrant groups in the Basque Country, or older adults in other settings in France, or by including social participatory strategies in the designing of projects, or integrating interactive didactics in training activities, or focusing in the local civil society organizations' critical role in the implementation of community projects.

All these aspects are considered as key dimensions of any health promotion process to be implemented with specific groups in Latin America. All this supports the relevance of the ISPED strategic movement to an open dialogue between the Latin American perspective of health promotion and the European hegemonic approaches found at an academic and political level.

A Virtual Teaching and Learning Modality

Offering a master's degree in health promotion in a virtual modality represented, at the time, a clearly innovative proposal. In 2013, although there were already some other distance training programs, the offer of an online master's degree in health promotion was very limited, if not nonexistent, both in the Latin American region and in Europe. This master's learning modality, together with a high level of academic excellence, explains the interest that arose in both regions. At this time, enrolled students come, in similar proportions, from both sides of the Atlantic (see Fig. 5.2). The diversity of students' background represents a benefit as it takes into account the continuous training demands of professionals already engaged in the labor market regardless of their place of residence. They also contribute to the democratization of access to formal knowledge and continuous development.

Total admitted 2013 to 2020	60	
Total graduated 2014 to 2020	44	(73.3%)
Number admitted 2020	19	
Mean number of admitted 2013 to 2020	10	

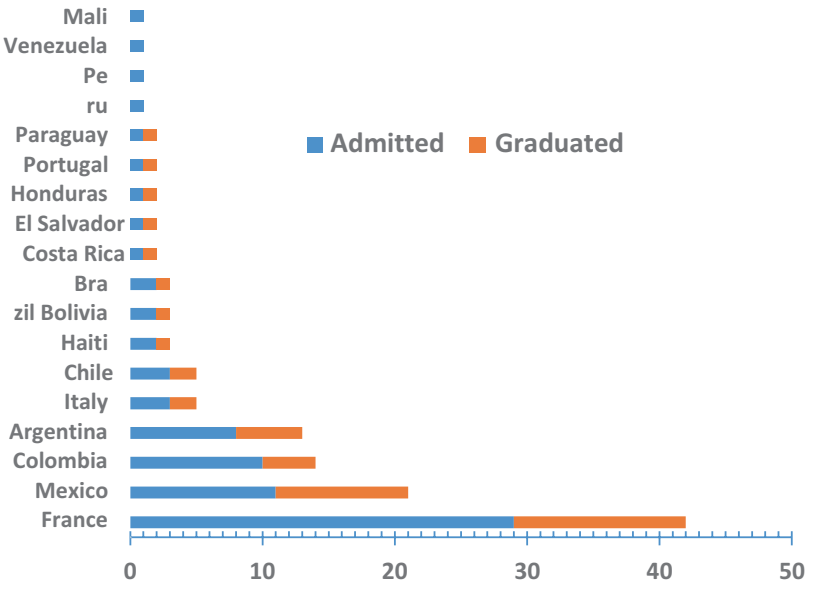

Fig. 5.2 Admissions to and graduations from iPROMS, by origin of students, 2013–2020. Figures are absolute numbers; percent graduated calculated excluding latest promotion (2020), who will graduate at the end of 2021

Total admitted from Spain and Latin America	64	(81.0%)

Within this virtual environment, which is flexible in terms of calendar and connection schedules to the online teaching platform, the Latin American team has introduced some innovations conducive to mutual learning (including for the faculties, students, and institutions) following a dialogic and participatory process. Synchronous exchanges have been added through various platforms and social networks, group, or individual sessions, and taking into account conflicting students' time schedules, the learning needs of each module, and the specific profile of each master's cohort. These virtual conversations, "face to face" and in real time, have made it possible to deploy all the potentialities of group learning, making the most of the diversity of experiences and training backgrounds to efficiently address the complexity of health promotion actions in specific contexts. This distance learning modality, essentially asynchronous—but with synchronous encounters responding to the cohorts' internal dynamics and the evolution of the different modules—had a positive impact not only on the learning process but also on students' motivation, particularly for the production of final assignments and the master's thesis through individual tutoring sessions.

A Critical Orientation Toward Action and Social Change as a Basis for a New Perspective That Transforms Unequal Realities

The conception of health promotion as an action-oriented discipline aimed at social change is another substantive aspect of the master's program. This approach focuses on health promotion practices with different populations or in different environments and aims to train professionals who can participate in processes of change from a critical perspective. Indeed, the master's degree incorporates tools for critical action for social change allowing an examination of health promotion practices to understand the factors that influence success. In this sense, the training promotes collaborative, multisectorial, and transversal action, fostering citizen participation.

In line with this approach, the master's program incorporates health promotion values and principles of action aimed at transforming the unequal realities that affect people's living conditions. This critical approach goes beyond traditional discourses that fail to challenge enduring inequality and social injustice and thereby to transform the world and the institutions. Precisely because of this discursive risk, it is essential to make of this critical review a momentum of individual and collective reflexivity, so that the professionals enrolled in the master's program can understand, relate, and properly use health promotion resources and tools, starting by the attempt to integrate them critically (and not at all mechanically nor merely formally) in the process of elaboration of the final master's thesis. A critical first step for each student will be therefore to anticipate, and certainly confront, the challenge that will come a little later from the application of this critical view in concrete professional practice.

Among the different cohorts, the number of professionals motivated to reformulate the experiences that dissociated them from the reality of the field and left them isolated in the discursive sphere have been noted, in particular their final thesis where they were able to develop projects and interventions in different settings. As expressed by students in forum discussions and course final evaluations, this academic experience allowed for the recognition and application of the most powerful discourse to generate a new perspective. A perspective materialized in new ways of conceiving the design, implementation, and evaluation of health promotion interventions allowing to put forward concrete actions to tackle the social determinants of health, to name health inequities, and/or to visualize gender and diversity approaches. It is a matter, then, of highlighting the need to operationalize health promotion discourse to act on specific populations, environments, and situations.

Lessons Learned, Challenges, and Future Scenarios

In this section, we point out aspects related to the development and sustainability of the master's program, as well as its validity as a training program with a strong networking and development goal. It is well established that a success criterion for

an academic program is based on quality and sustainability. This involves taking into account a permanent process of adjustments, based on internal and external evaluation mechanisms. It requires critical analysis for oxygenating and permanently nurturing the project in relation to its contents, methodological approaches, bibliography, and interactive tools including individual and group tutoring sessions and online forums. Likewise, the sustainability of a project is a result of contextual factors such as available funding, institutional support, and the capacity to take advantage of technological development in order to attract and maintain the interest of students.

In addition to students' inputs on the master's program and its learning outcomes by means of an online questionnaire administered to the students at the end of each curricular module, the dynamics that have sustained this proposal over the last 10 years are not separated from the strong connection created between faculty members and students. Considering professional and generational trajectories, they both have the possibility of choosing what kind of training activities they are interested in, which scientific fields, and which domains of investigation and collaboration. The possibility of fostering a close bond between faculty and students, of intertwining and interweaving aspects of their personal and professional experiences in an environment of honesty and warmth, generates an affective asset that favors a collective learning process. Working with relatively small groups makes it possible to generate a learning climate that is better targeted, more attentive, and inclusive than other teaching and learning experiences.

The master's program enrolls between ten and fourteen students each year, almost at the limits of its economic sustainability. This situation reflects an approach that is proposed as most appropriate for a training program in health promotion, in which the learning process is not limited to the acquisition of knowledge or the accomplishment of a number of exercises that are fixed to binary responses, true or false, or similar, but mainly underpinned by a critical reflection on experiences and problems that involve more in-depth exchanges between students and the faculty.

Fundamental to the process is an intensive week of face-to-face sessions taking place in one of the partner universities in Europe. During this particular week of classes, participants engage face to face with their fellow master's students and faculty, share their learnings, build bridges, and get closer to the faculty members. This key learning phase contributes to creating a mystique that is relevant in an academic program that addresses social and community aspects and has been appreciated by students as part of an integral training process.

Jorge Luis Borges recalls that ancient navigators, when they set out to discover unknown worlds and fantastically idealized treasures, carried with them maps that, while being precarious and imperfect, were complemented by having on one or two cartographers on board to record encountered pitfalls and identify the most suitable routes. Perhaps today it is necessary to have a cartographer onboard, a cartographer that is capable of understanding and informing decisions, recognizing progress, and also recording the landscape of questions and uncertainties that we need to address in order to understand where we are going.

Notwithstanding the particular value of online teaching and learning in this particular context, it is also important to consider aspects that often go beyond training but influence it.

The search for bonding referents, which are often demanded by students to diminish the fear, uncertainty, isolation, and loneliness that can be experienced in a distance education program, should be appreciated and taken into account. At this point, some of the quality aspects mentioned above should be complemented with tools that bring warmth and nearness to the teaching and tutoring work. The academic program must not only be flexible but also offer the greatest possible interconnection between the different resources and virtual tools.

Academic Training (Academic Oriented) vs. Professional Training (Practice Oriented)

An important debate for post-graduate training programs in health promotion is related to the type of orientation: professional vs. academic. As far as this training experience is concerned, notwithstanding the need to develop a professional workforce, we wanted to strengthen the research component. Up to date, this research component has only been incipient and hinders the possibility of subsequent academic developments, such as scientific publications and doctoral itineraries. Along these lines, the opportunities for students to opt for a research orientation in their master's should be expanded. This would entail strengthening links with research teams and PhD programs at partner universities, as well as reinforcing pedagogical and competency-based approaches to research, scientific writing, and communication.

In accordance with perspectives that the master's program seeks to promote, the capacity of the alumni to access, generate, and utilize evidence becomes particularly relevant. It highlights the need to strengthen and update the body of knowledge and practices of health promotion based on both scientific and social evidence. This is a favorable field for training, which can enrich the curricular program by continuously introducing new content through a combination of applied research, change-oriented practices and knowledge development and sharing.

Questioning Hegemonic Approaches and Confronting Teaching Models

The proposal has integrated specific contributions defined as non-hegemonic in terms of language (the program is in Spanish) and based on a North-South dialogue aimed at integrating and stimulating heterogeneous contributions. The master's degree is bred from its European roots as a conventional training program in public health and preventive medicine with a particular focus on clinical approaches to prevent illness and to promote health. This is consistent with the different students' profiles enrolled every year (health, social sciences, education). The discussion surrounding different pedagogical models, approaches, contents, accreditation processes, and student profiles shows the need to tailor content according to the type of

training proposed, integrating health promotion and disease prevention approaches from Europe and Latin America and to recognize existing differences in their respective focus and curricular content and, at the same time, to see how to harmonize both approaches in the master's program.

Learning Achievements

The learning experience over the last 13 years (including the professional study programs and the master's degree) has resulted in a continuous process of adaptation and evolution that is based on an intentional sensitivity to changes in the context and the needs of students. This process can be appreciated through the revision of the master's syllabus over the years, both through individual and institutional adjustments. This is essential to avoid discursive and theoretical inertias which frequently take place in more rigid institutional and academic formats. One of the most important dimensions of the learning and teaching modality is the process of permanent revision of the Master's program to remain responsive to the needs and interests of students but also to teachers' proposals on new emerging issues. Thus, this updating process has two main sources: (1) the advance in knowledge, new problems, and new evidence and (2) the new knowledge resulting from students' demands and from interactions with and within the group. However, a flexible curricular model had always to guarantee the basic academic proposal as a conceptual and ethical hardcore.

Such flexibility results from a dialogic relationship between professionals, students, and teachers allowing attentive listening that leads to a sensitive reformulation of the master's syllabus. This has been a constitutive element of the master's program from the very beginning and has translated into many opportunities to expand faculty-student relationship beyond diachronic exchanges.

One of the main challenges of health promotion today is to transform its rhetoric into tangible strategies of social and community transformation. Within the virtual framework, there is an ongoing dialogic relationship with regard to the contents and working method which avoids the dilemma of "all virtual." This encourages the construction of belongings and community ties grounded up to a virtual environment and a virtual world.

For this reason, following the Borgen orientation, in this proposal, we experienced, in many moments, the role of the cartographer, close and available, motivating and challenging, in face-to-face virtual sessions, individual, or group, accompanying the integral learning processes, which include recognizing and working on uncertainties, fears, loneliness, and resistances. The pedagogical challenge ahead is how to incorporate and manage this key new dimension of the role of the online teacher in an online-only proposal without falling into an "on-demand" dynamic or the traditional role.

Thinking in Terms of Community

The potential development of a community of learning and practice is to be highlighted as a current challenge: analyzing what could have been done in this regard and expanding future possibilities to advance this. For such a cooperation and learning environment to function, it is necessary to have an institutional perspective that develops a strategic plan and defines both a vision and a roadmap.

A community of practice and learning generates, in addition to knowledge, possibilities for the development of competencies related to care, mutual help, and the sharing of experiences, learning, and intervention resources. Currently, there is a WhatsApp group that adds integration to this project. The idea of forming an alumni network should be further pursued and supported.

Conclusions

Integrating knowledge and experiences from the Southern and Northern hemisphere within a shared vision and even contribution has been key to this health promotion training and development program. This approach has generated a common landscape of opportunities and resources of meaningful use by a process of mutual knowledge and exchange of conceptual frameworks, methods, and tools applied in the two hemispheres which is key to tackle the health promotion professionals' challenges of the twenty-first century (see Fig. 5.3).

When we consider the deepening of asymmetries and inequalities that have been crudely evidenced by the COVID-19 pandemic, this becomes vital. The production

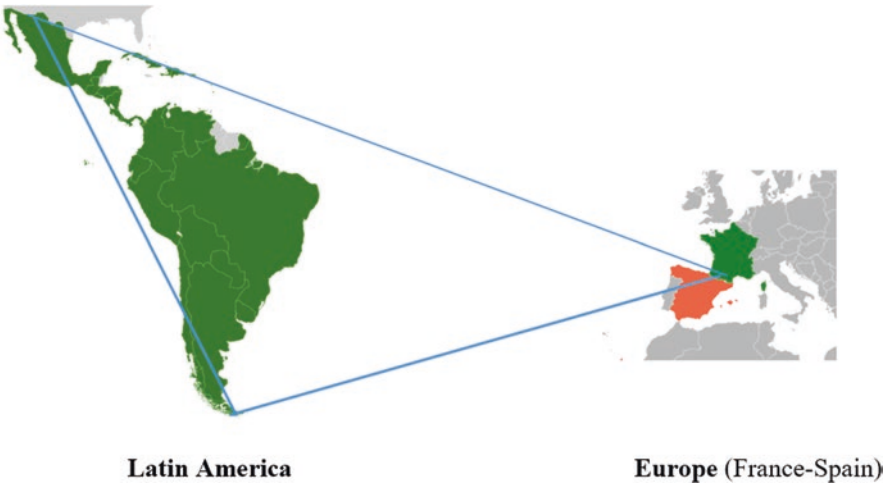

Fig. 5.3 The Master iPROMS as a three-pronged move

Table 5.3 Authors' reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	HP is an opportunity for social transformation that seeks to surpass rhetoric. Limited not just to a political and technical tool, this strategic movement captures a vision of equity with a focus on human rights and community participation. In other words, a health promotion approach integrating ethics, dialog, and practice. It is also aimed at transforming the complex determinants that shape people's citizenship, quality of life, and health-illness continuum, all this, for all people, without exclusions or discrimination
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	The creation of an international training program in health promotion in Spanish and online born in 2008 at the ISPED was a strategic opening toward the Latino-American region and strongly supported by the presidency of the University of Bordeaux. The participants responded to different disciplines related with health and from different geographic contexts
Which theories and methodologies are used in the teaching-learning process?	An innovative pedagogical project that combines classical and constructivist approaches built upon the critical paradigm and led by a teaching team highly committed to its shared vision with an understanding of the issues to be covered and also associated challenges
What kind of forms of assessment are applied, results achieved, and challenges faced?	The systematic attitude of critical reflection on the complexity of health promotion in specific contexts and taking into account the globalized scene. Stimulation of a critical dialogue between the experiences of the south and the north can be seen in the resonance of the curricular contents amongst the participant professions
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	Communication in health Research methods Project planning and management Evaluation of health promotion programs Advocacy
What could others learn with your experience? What is localized and what is "generalizable"?	The dynamics that have sustained this proposal over the last 10 years are not separated from the strong connection created between faculty members and students. Considering professional and generational trajectories. The possibility of fostering a close bond between faculty and students, of intertwining and interweaving aspects of their personal and professional experiences in an environment of honesty and warmth, generates an affective asset that favors a collective learning process. Working with relatively small groups makes it possible to generate a learning climate that is better targeted, more attentive, and inclusive than other teaching and learning experiences. It becomes difficult to establish a limit between what is localized and what is generalizable. Each cohort of students have their own characteristics that could make this experience more restricted to confined spaces and others that could be part of a scaling-up process

and distribution of healthcare supplies and vaccines, as well as the primacy of economistic approaches to the response to the pandemic that denies health as a public good, confirm a mercantilist conception of healthcare that is dominant in many countries, contradicting to the values of universal access to healthcare for all.

In this context, the countercultural perspective of the Master iPROMS remains valid and necessary. It creates a space that allows professionals from different countries to think about their reality in a globalized world from critical and action-oriented perspectives.

Table 5.3 brings our reflection on the six triggering questions suggested by the Editors.

Acknowledgment Wendy McGovern (Cambridge, New Zealand) – English translation.

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Chapter 6
The Disappearing Contribution of Universities in the UK to Health Promotion

Jane Wills, Susie Sykes, and Andrew Trasolini

Contents

Background

In the last few decades, there has been a huge cultural shift in the ways we think about health, from not being ill or having access to medical care to a fundamental human right to be well or fulfilled. Health promotion (HP) is the field of activity, disciplinary area and approach that has been at the forefront of shaping this thinking and connecting to most of the core concepts that now inform approaches to health

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and healthcare: participation, involvement and engagement, empowerment and control, person-centredness and equity and social justice.

The development of HP in the UK over the past 50 years makes a fascinating study reflecting the dominant political ideologies and changing views on health as a medical and social goal. It merits particular attention because there is little existing documented history and within health and social care, its development is particularly unusual. The origins of HP in the health education movement of the 1970s in the UK led to rapid expansion in the next decade. An emerging and flourishing discourse followed with 22 published models examining its nature in the 1980s (Rawson, 1992). While there was both concern and a shared understanding over the prevention of disease, there was little consensus about what was meant by the promotion of health. The policy environment was not politically receptive to the principles of health promotion enshrined in the Ottawa Charter (1986). National policy over 50 years envisaged health promotion as giving the public information to lead healthier lives with the focus on the prevention of disease and injury reflecting the domination of welfare discourse by neoliberal consumerist values. In the 1980s, many of those working in health promotion thus saw themselves as proposing and disseminating an alternative agenda for action for health (e.g. Adams & Slavin, 1985). Historical accounts bear witness to a movement of committed activists, shifts in thinking about health including the need to assess all policy for its impact on health and major achievements in targeted and culturally sensitive programmes for specific segments of the population, e.g. older people, young people, women, migrants, people with a disability and people with a long term condition (e.g. Berridge et al., 2006; Wills et al., 2008).

Specialised health promotion is an internationally recognised occupation and field of activity, but it has had a chequered history in the UK reflecting the dominant political ideologies and changing views on health as a medical and social goal (Duncan, 2013). Until 2013, primary care organisations had departments called health education, then health promotion and, latterly, health improvement. Their activities included helping organisations such as schools to focus on health, developing local strategies to tackle key issues such as alcohol use as well as developing the skills and abilities of individuals, communities and groups and training professionals to tackle health issues. In recent years, these activities became subsumed under an umbrella of public health and moved to local government with job titles of Health Improvement Specialist replacing that of Health Promotion Specialist. Public health is said to include three domains of practice: service improvement, health protection and health improvement; however, health promotion was not mentioned. In England, specialised practice is aligned to a voluntary register called the UK Public Health Register (UKPHR) (https://ukphr.org/) which has a set of standards for practitioners (https://ukphr.org/wp-content/uploads/2019/07/UKPHR-Practitioner-Standards-2018-2nd-Ed.pdf):

1. Practising professionally, ethically and legally
2. Using public health information to influence population health and wellbeing
3. Assessing the evidence for public health interventions and services

4. Protecting the public from health risks while addressing differences in risk exposure and outcomes
5. Implementing public health policy and strategy
6. Collaborating across organisations and boundaries to deliver the public health function
7. Planning, implementing and evaluating public health programmes and projects
8. Communicating with others to improve health outcomes and reduce health inequalities

Neither the terms health promotion nor health improvement are mentioned, and the standards for practice illustrate the merging with public health. It could be, that as McQueen (2007) states: that health promotion concepts and principles have become so instilled into the practice of public health they may not need distinguishing. But then as McQueen also questions: one must examine carefully why there is or is not "a name on a door".

In March 2021, the government in England proposed a new Office for Health Promotion to replace the previous lead body Public Health England. Within a few months, the name was changed to Office for Health Improvement and Disparities. The new body sits within government aiming to embed good health across the work of the whole government and health service.

Health Promotion in Universities in the UK

Academic health promotion plays an essential role not only in preparing students for practice and in workforce development but also in developing the theory behind practice. Against the dominant medical paradigm, it also plays a crucial role in defending health promotion, developing the evidence base to show whether and how it works and creating and maintaining health promotion as a social movement with a radical purpose. The universities' initial role in the UK was to develop this discourse, often within wider fields of sociology or social policy, yet in contrast to its development in other countries and to the emergence of other "semi-disciplines" such as social work or nursing, it has not been established as a disciplinary area in the UK.

To help identify if health promotion is a field of study with a specific knowledge domain, we conducted a rigorous search in 2021. This showed that there are 29 universities of 130 in the UK offering 43 courses in health promotion at undergraduate level and only four that include health promotion in the award title and always linked with either Public Health, Physical Activity or with Social Care. Ten universities offer a postgraduate award with health promotion in the title, eight of whom link it with public health. In addition, one university has a postgraduate Masters in Education, Health Promotion and International Development, and another has a postgraduate Masters in Global Mental Health with Specialism in Health Promotion.

Is this difficulty in locating a discrete university course simply an issue for the UK? We used the search engine "hotcoursesabroad" to conduct a similar search at universities in Australia. Through this, we found seven universities in Australia of which the University of Queensland in Australia is listed as having 16 health promotion courses. Not one of these courses is discretely about health promotion – those with health promotion in the award title were linked with disease prevention suggesting that the situation in the UK is replicated elsewhere.

The establishment of Professorships in health promotion is another recognition of a discipline base, and that one could hold expertise *in* an area of knowledge. A search for Professors of Health Promotion on Google found one currently in the UK and a Professor of Health Promotion and Public Health. By contrast, Dalhousie University in Canada alone has nine Professors of Health Promotion. They are, however, all located in a School of Health and Human Performance within the Faculty of Health Professions where the majority of research relates to kinesiology and leisure. Similarly, in the UK, there are other Professors with affiliation to the discipline of health promotion but who have other titles, e.g. Health and Sustainability or Healthy Communities or Health and Wellbeing. This lack of visibility, according to McQueen (2007), not only signals the lack of a disciplinary development but also heralds the idea that health promotion is an area that cuts across disciplines. Thus, teaching about obesity, for example, allows for the drawing from epidemiology in the describing of the disease burden and psychology and the understanding of eating behaviours, sociology and the social construction of fatness, social policy and the impact of legislative actions and to human geography and the influence of obesogenic environments and many more disciplinary perspectives.

If health promotion is not a discipline, is it then a profession? Most universities describe their courses in relation to a job market and employability which include, for example, as programme coordinators or commissioners for local public health, health project coordinators for voluntary sector organisations, young peoples' welfare or sexual health advisers in a college or primary prevention setting. Only one university, however, refers to a competency framework [Public Health Skills and Knowledge Framework at https://www.gov.uk/government/publications/public-health-skills-and-knowledge-framework-phskf].

Content of Health Promotion Courses

A scoping review of courses at undergraduate and postgraduate levels in the UK that includes health promotion in the award had the typical content presented in Table 6.1.

In a typical postgraduate degree, MSc Health Promotion courses often offer only one to two modules with health promotion in the title, the others being research, public health statistics or epidemiology. There are few courses which offer more than two health promotion modules in their curriculum. Health promotion modules

Table 6.1 Typical content of health promotion courses

Undergraduate	Postgraduate
Lifestyle issues	Principles of health promotion
Environment and health	Approaches and methods
	Foundations in health promotion
Communicating health information	Evidence and communication. Health communication
Contemporary issues	Health and society
Life stages development	Health policy, politics and social justice. People, power and communities. Policies for the twenty-first century
Working in teams	Implementing change in public health and health promotion. Developing programmes and evaluation

are, in some cases, offered as optional modules alongside core modules that are aligned to public health.

In contrast to the health promotion courses offered prior to the twenty-first century when, for example, the MSc Health Promotion at London South Bank University had two of the six modules on health promotion theory, current courses lack a paradigm building of health promotion. Several courses have modules that refer to "principles" or "foundations" of health promotion, but none suggest an examination of its theoretical and epistemological foundations.

The analysis of academic provision confirms how health promotion has become subsumed by the positivist discipline of public health or health psychology that does not have an articulated values base (Wills & Woodhead, 2004). As Tremblay and Richard (2014 p. 380) state: "Health Promotion has not been differentiated sufficiently from similar fields to have found its place politically and academically". If, as McQueen argues, health promotion is more "a field of action" than an ideological stance or "ethos", then the cardinal principles of participation, empowerment, social justice and positive health (Rootman et al., 2001) and the stories of individuals and communities about their everyday experiences of health would need to be centre stage. Yet the current academic provision risks these values getting lost against the aim of describing and analysing the disease burden.

In order to better understand what a health promotion curriculum might be for the mid-twenty-first century and on the 70th anniversary of the International Union of Health Promotion and Education, we organised a witness seminar. This is a well-recognised form of oral history, where people associated with health promotion come together to collectively recount, discuss and record their memories and their views of the future. A number of witness seminars have been conducted by the Wellcome Trust History of Twentieth Century Medicine Group. Witness seminars exploring aspects of the history of UK public health have addressed the Black Report (Berridge & Blume, 2003) and public health and health promotion in the 1980s and 1990s (Berridge et al., 2006). It is recognised that the accounts that participants give are based on their memories, sometimes of events that occurred some years before.

The ten participants were all UK academics who are teaching or have taught health promotion over many years. They were asked about the changes they had seen in the teaching of health promotion over their career; their views on health promotion as a discipline; and its curriculum and their views about the health promotion education of the future. The themes arising from this discourse are captured below.

What Is Distinctive About an Education in Health Promotion?

The positioning of health promotion within awards that also have Public Health in the title was highlighted by participants and was attributed to a changing political landscape in the UK and the loss of health promotion in the "general discourse around health roles". Several of the participants pointed to a change c. 1990 when the terminology shifted in England to "health improvement". One participant pointed out that there had never been a lead agency for Health Promotion in England until March 2021 when an Office for Health Promotion was set up by the government, but this swiftly had a name change.

> *I think Canada's had similar issues around whether you're talking about public health, whether you're talking about population health, whether you're talking about community health, whether you're talking about health promotion. I don't think we're unique. [Participant 1]*

One of a handful of academics who offer a course at postgraduate level in health promotion contrasted it with public health which she characterised as being about "data". Another participant offered a multidisciplinary public health course and, although describing it as having a health promotion focus, similarly referred to health economics, epidemiology and advanced statistics as distinguishing it from health promotion. Another participant in describing a course in "the health promotion tradition" outlined its features:

> *We always had epidemiology there, although not at a very sophisticated level, we always had a lot of community, some of our filming and so on and face-to-face work was about community. We always had stuff on policy and developing healthy policies, we always had stuff on environment and sustainability, and we always tried to address issues of different population groups to vulnerabilities, and mental health, for example. So it was a very broad brush course [Participant 2]*

A participant from Scotland who leads a course in Health Sector leadership remarked that:

> *I think a lot of our graduates go into leadership roles across the whole sector, so in the care sector, housing, transport, planning. So a lot of the work we do definitely is of a health promotion nature, but it's not labelled as that, it's just labelled as kind of generic, good practice*. [Participant 3]

For some of the participants, retaining a distinctive focus and award in health promotion was very important, but one participant argued that:

…do we try to almost fight for health promotion remaining in the language, or is it about the values, distinctiveness and content being integrated into public health or whatever else the language might be… [Participant 1]

Is It Values That Make Health Promotion Distinctive?

All of the participants agreed that there is a common set of values and principles that inform health promotion of empowerment and community working and a focus on reducing inequalities. This lens of social justice is one that contrasts health promotion with what is in the UK, a more dominant discipline of public health. One participant contrasted this as the political tradition of health promotion v. the technical tradition of public health:

In health promotion it's been very difficult to ignore the fact that what people want to do is they want to change a community at health policy level, they want to experiment and they're willing to try. You know, I think what public health has done is to try and push back against that in terms of the need for evidence and the emphasis, the over-emphasis, in my view, of evidence to some extent, and the need for technical competence, and that seems to me to have been a tension throughout. [Participant 2]

Participants saw the pandemic as epitomising the operationalising of the values of health promotion: addressing the inequalities that led to the disproportionate burden of disease falling on the poor and BME groups; the evidence of community involvement and participation as communities mobilised and offered mutual aid, collaborative working across the health service, local government and the voluntary sectors; and the inextricable links between how people are treated and how we are treating the planet in the whole paradigm of One Health zoonoses. One participant reminded that the reason in the past that people wanted to study health promotion was because they had come from a background of community activism – whether in women's health, LGBTQ+ campaigning or Black rights.

I think that in the future we're going to have far more people wanting to do health promotion courses that are going to be coming from a community activist base. So therefore, in our curricula we have to focus on activism, not just community action but activism, and what we mean by activism and what does this mean in terms of enabling political change. [Participant 4]

What Should Be Included in an Education in Health Promotion?

There was a consensus that the Ottawa Charter provided a basic framework for a curriculum and acts as a reference point for the ways in which courses are structured:

I think that the Ottawa Charter still provides a really important framework for guiding any curriculum. I think that there are some things which have happened in the last 30 odd years where we need to shift and strengthen, and I guess that's probably reflected in the kind of aligning with sustainability in a number of courses, but I think the focus on equity and actu-

ally the focus on wellbeing in, I would say, its true sense rather than the fairly superficial happiness sense that wellbeing is often talked about these days, is something that health promotion brings. [Participant 1]

There was an awareness that there are some changes and developments since 1986, and this is evidenced in the alignment of health promotion with sustainability:

The convergence of health, well health of people, health of places, health of the planet, is crucial. Although the seeds of that were there in the Ottawa Charter and the language of sustainability wasn't even around in 1986, so clearly there are things that need to shift, and I think the language health in all policies, I mean, it talks about 'healthy public policy', but actually there have been, I would say, significant evolution in what health in all policy and governance for health requires. [Participant 1]

Just as participants outlined a tension in university courses between those aligned with public health and those remaining as a discrete health promotion offer, so they also outlined a tension between academic study of the theoretical basis of health promotion and those courses that are vocational and oriented towards employment. Most participants felt that they wanted their courses to be academic, allowing for discussion and debate on concepts and theories and developing students' levels of scholarship and research skills, but felt pushed towards vocational elements.

There was a strong feeling that a course in health promotion should be applied. It should have a clear link to practice:

There's always been a feeling that we've got to raise awareness without necessarily giving the students the specifics of what the applied version of these ideas actually are and what the nature of policy making is, for example, and the political nature of that. [Participant 4]

Because those studying health promotion, particularly at postgraduate level, come from a range of backgrounds, often with a training in another occupation such as nursing, midwifery and occupational therapy, and are usually studying part time alongside their dominant professional training, there is a need to socialise students into a different discipline. The space and direction in the curriculum for reflection are thus essential. For several of the participants, providing placements allows students to gain an understanding of the breadth and opportunities for health promotion practice across sectors, for example, within urban planning, to put a health promotion lens on or alongside other lenses.

Students go out and experience interacting with members of the public around health promotion issues, and also very much embed themselves with working within the third sector….. partnership working and advocacy are really key components, but they're skills and competencies in health promotion. [Participant 5]

Should an Education in Health Promotion Be Linked to Competencies?

Only one of the participants' courses was said to be mapped against a competency framework – the IUHPE core competencies and professional standards for health promotion (https://www.iuhpe.org/images/JC-Accreditation/Core_

Competencies_Standards_linkE.pdf). The other participants did not claim that their courses linked directly to an area of professional practice:

> *I think the competencies side of things, I think competencies are clearly really important, but when it comes to skill based competencies, it's much easier to attach those to a course if it does have a strong vocational or career path that's clear; if it doesn't, then it's actually quite hard I think to base it... well not to base it around competencies but to be sure that those competencies are going to be the right ones going forward. [Participant 1]*

All of the participants offered courses at postgraduate level but eschewed undergraduate level because of the lack of a clear career path into health promotion practice:

> *I think the problem at undergraduate level is around the career trajectory for health promotion for an undergraduate, typical student just isn't there, and therefore it's really difficult for us to offer a BSc in Health Promotion or a BA in Health Promotion because the government want to see outcomes around employability, and I just think that's a really difficult thing for us to do because it's not explicit enough, as we all know at the moment. [Participant 6]*

Where to Now: A Curriculum for the Mid-twenty-first Century

Participants felt strongly that planetary health should be part of an education in health promotion but expressed concern that its current attention should not "drive to the margins the focus on health inequalities".

There were mixed views about the benefit of a discrete health promotion course or whether it can achieve greater prominence in a basket of other courses. Several participants described their courses having large numbers of international students for whom the award title and focus on health promotion was not seen as unattractive or not useful. Those participants who had taught internationally also had not experienced the challenges in presenting and promoting health promotion:

> *In x university, you didn't have any problems with this, there was like a bit of blue water between health promotion and public health and it was easily understood.*
>
> *Working in South Africa, in all the health promoting settings, especially around the schools, health promotion was just so easily understood in terms of the values that we've been discussing. [Participant 7]*

The participants concluded that rather than considering the content of the curriculum, the focus should be on how health promotion is presented:

> *I feel that the health promotion, the breadth, the depth, the skills that are collaboratively brought together through health promotion, you know, would be a huge asset in terms of tackling some of the big, as we used to call some of them, wicked issues, but some of the major problems and issues around mental health etc. that we are now going to be dealing with for the next many years. So I don't want to say 'rebranding', but I want to say strengthening or visibility or something about the understanding of what health promotion. [Participant 2]*

Conclusions

This review yielded no consensus on whether health promotion should sit alone or in a basket of other courses. Without a consensus, there is no template for a curriculum or how content should be organised. As long as health promotion sits alongside some other discipline, such as public health or psychology, then the focus on enablers of health and the whole government approach will be lost.

Fifty years ago in 1972, three UK universities were asked to provide health education specialist training by the then Department of Health with students studying full time on bursaries. There was a consensus amongst those taking part in this review that university education is now market-driven and that means it is about preparing students for employability. This review had much talk of the values underpinning health promotion, but without a competency framework that reflects those values and principles, there is nothing against which to package a marketable course.

This might be a moment of change for health promotion in the UK. The pandemic has spotlighted the importance of health promotion and enabling people to increase control over their health by adopting protective actions, supporting and mobilising in their communities and contributing to policies (Van den Broucke, 2020). The UK hosted the UN Climate Change Conference (COP 26) in 2021 which focuses attention on how human health is affected by planetary health and the contributions of health promotion interventions such as active travel and healthy sustainable diets. The Black Lives Matter movement has focused attention that the intersection of the social determinants and race must be addressed (Leitch et al., 2021).

Table 6.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 6.2 Authors' reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	The chapter concludes that most provision in the UK is based or informed by the Ottawa Charter
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	Most courses are not discrete health promotion courses but are part of public health. They are mostly postgraduate and attract students from a range of other professional backgrounds, predominantly nursing
Which theories and methodologies are used in the teaching-learning process?	Mostly they draw from social sciences rather than biomedical sciences and so psychology, education, communication
What kind of forms of assessment are applied, results achieved, and challenges faced?	Not discussed
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	Most courses are not competency based; one is based on the Galway Consensus
What could others learn with your experience? What is localised and what is "generalisable"?	The chapter makes the argument that health promotion as a discrete discipline may disappear. Its distinctiveness needs to be maintained. This lies in its values and commitment to social justice

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Chapter 7
Health Promotion Teaching and Learning at the University of the Western Cape, South Africa: Thinking Global, Acting Local

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Vision for Health Promotion

Our vision for health promotion is to create a professional and competent workforce with the appropriate skills and knowledge to address the basic social, economic and political causes of ill-health through advocacy and lobbying of government and policymakers and includes intersectoral interventions and involvement of various stakeholders at different levels of society including communities themselves. Health promotion should have a wide range of strategies aimed at improving people's health. This is a departure from the earlier emphasis on disease prevention and as such should be part of the responsibility of a range of professionals. The focus should be on positive health and on prevention which responds to the ethics and morality to which our society might aspire.

Institutional and Political Context of the University of the Western Cape

The University of the Western Cape (UWC) is well-known for its struggle against apartheid and its continued fight against discrimination and disadvantage in South Africa. UWC has played a key role in the transformation to a democratic dispensation, and one of its primary foci for the future is "to help build an equitable and dynamic society". Apart from disseminating knowledge that is "relevant to the challenges of a modern world and transforming society", it also aspires to be an agent of change (UWC, 2021).

Only "Coloured" students were allowed to enrol when UWC was first established in 1960. They were offered limited training for lower- to middle-level positions in schools and other civil service institutions catering for the Coloured community. However, in 1982, the university formally rejected the apartheid ideology on which it was established, adopting a declaration of non-racialism and "a firm commitment to the development of the Third World communities in South Africa". In 1987, UWC aligned with the mass democratic movement to become "an intellectual home of the left", with curriculum renewal, innovative research and outreach projects. Important social and policy issues, which had been swept under the carpet by the apartheid government, came under scrutiny. The university provided access to an increasing number of African students with its "open" admissions policy. Despite severe constraints, students from disadvantaged communities graduated in numbers, equipped to make a professional contribution to the new democratic South Africa. President Nelson Mandela praised UWC for having transformed itself "from an apartheid ethnic institution to a proud national asset" (UWC, 2021).

Against this background, the UWC School of Public Health (SOPH) was envisioned by one of the UWC Vice-Chancellors, Prof Jakes Gerwel.

The Origins and Ethos of the School of Public Health

The visionary Jakes Gerwel advocated passionately for the development of South Africa's first SOPH. He saw the need for UWC to focus on public health research and practice that would lead to improvements in people's health and policy. The SOPH was established in 1993 as a Public Health Programme under the leadership of Prof. David Sanders. It was the first institution to offer a Master's of Public Health (MPH) in South Africa. Since its inception, SOPH has established itself as a significant pioneering initiative in public health with a national and ever-increasing continental influence. Prof Sanders' legacy as a founder of the SOPH is well recognised for his considerable contributions to UWC and the field of public health in general, both locally and internationally.

The vision of SOPH is:

> *To contribute to the optimal health of populations living in a healthy and sustainable environment in developing countries, particularly Africa, with access to an appropriate, high quality, comprehensive and equitable health system, based on a human rights approach.*

Its purpose is to strengthen education and research in public health and primary healthcare and to build capacity in the health services.

When the Public Health Programme was established in 1993, public health education in South Africa was concentrated in university medical faculties and did not cater for the broad range of allied health professionals working in health, welfare and education services. Incidentally, UWC has a Community and Health Sciences Faculty but does not include a medical school to train doctors. The SOPH is situated in this faculty, which also includes the Departments of Occupational Therapy; Physiotherapy; Social Work; Natural Medicine; Human Ecology and Dietetics; Sport, Recreation and Exercise Science; Nursing; and Psychology.

The newly democratic South Africa was also beginning to address the inequities in the public health system which it had inherited. This meant addressing the extremely unequal provision of health services along racial lines. Developing public health education for multidisciplinary health and social sector professionals in the country was an important contribution towards achieving this goal. Transforming the health sector from a largely curative, hospital-based service to a high-quality, equitable, comprehensive community-based system required health practitioners to engage in new roles and to develop new skills. This then became the SOPH's mandate to fulfil.

By 1994, a part-time Master's programme was delivered during teaching blocks offered through short courses in winter and summer schools and independent study periods. However, in the context of the crisis of human resources for health in Africa, the training programmes of health professionals in crucial public health roles was not envisioned to disrupt the provision of health services. Therefore, there was acknowledgement that training with greater flexibility was needed: "New strategies had to be found to not only bring training opportunities to health workers, but also to train them while in post, using their own work situation as the practical arena in which to implement the theoretical concepts mastered" (Sanders et al., 2001:

824). This implied access to study opportunities while working, and distance education, as offered at SOPH, offered the potential to do exactly this (SOPH & UWC, 2009).

From 2000, the SOPH offered a multi-level programme which allowed health and welfare professionals to enter at levels suitable to their prior qualifications, to work and study at the same time and at their own pace and to graduate at a point which suits their own needs and abilities.

Public Health Programme

The SOPH contributes to much-needed public health education and training by offering:

- A multi-level postgraduate programme which includes a combination of distance learning and contact sessions
- Short courses offered by staff and visiting experts at annual winter and summer schools
- In-service training of practitioners in the field through participatory research and service development as well as commissioned short courses (SOPH & UWC, 2011)

The teaching staff also familiarise themselves with regulations and policies that affect the work of public sector staff, enabling them to choose topics that are relevant to the public sector as well as their training plans and to design content which meets the expressed need.

Postgraduate Programme

The postgraduate programme consists of three courses and qualifications:

- Postgraduate Diploma (PGD) in Public Health (NQF[1] Level 8)
  - Six compulsory modules delivered over 1 or 2 years (fast track with all six modules in 1 year for the former, or slow track with three modules per year for the latter), with health promotion being one of these modules
- Master of Public Health (MPH) (NQF Level 9)
  - Six compulsory modules (which includes health promotion and two research methodology modules), two elective modules chosen by the student, and a mini thesis
- PhD in Public Health (NQF Level 10)

[1] National Qualification Framework.

Short Courses

Winter and summer schools, which are contact sessions, are held annually with most courses having a duration of 1 week. They have been held since 1992 and are probably the largest continuing education programme in public health in Africa.

Winter school courses are open to actors in the broader health and social sectors who would like to undertake stand-alone short courses as part of their continued professional development, thereby providing opportunities to gain additional skills in current public health issues and practice. In addition, these short courses provide contact time for the SOPH postgraduate students. The summer school on the other hand is meant only for the postgraduate students (SOPH & UWC, 2017).

The short courses attract people from diverse professional and geographical backgrounds, which offer excellent opportunities for exchange of knowledge and experiences. Course convenors work deliberately with participants' experience and expertise, which provide rich resources for shared learning. The convenors also collaborate with colleagues from the Department of Health as well as civil society in offering these courses, which provides a different perspective on the topic under discussion.

Participants

The programme attracts students not only from South Africa but also from other African countries and beyond. The PGD in particular is aimed at health and social development managers, supervisors and educators who want public health knowledge and skills to transform their sector without necessarily having to do formal research, and practitioners trained in other disciplines, but now working in public health. It is appropriate for practitioners at local, district, provincial and national levels.

The MPH program is designed for a range of health professionals and those working in the health and social development field. It is particularly designed to support middle- to senior-level managers, who work at district, provincial or national levels, and staff of non-profit organisations and other academic research institutions.

Public sector staff as well as community-based structures contributing to health are regarded as primary audiences for the winter school (and our other educational programmes). Around 10–20% of winter school participants are SOPH postgraduate students from South Africa and beyond, with the balance being members of the public working in a range of settings and conducting health-related work, e.g. policy specialists, lab technicians, health economists, quality improvement specialists, pharmacists, fieldworkers, primary healthcare nurses, doctors, teachers, administrators, community health workers, dieticians, health inspectors, social workers, occupational health workers and teachers (SOPH & UWC, 2017) (see Box 7.1).

Box 7.1 Winter School Participants of the Health Promotion Course

- SOPH Postgraduate students
- Staff from South African state health departments (national, provincial and municipal)
- Staff from other South African state departments (e.g. social development and education)
- Staff from state departments and civil society organisations from other countries
- Members and staff of local civil society organisations
- Staff working in private/for-profit health-related services
- Local academics/researchers
- Academics/researchers from other countries

The students live and work mostly in Southern, East and West Africa. For example, in 2017–2018, as in previous years, 52% of students were from South Africa, 47% from other African countries and 1% from overseas (see Fig. 7.1) (SOPH & UWC, 2019).

Health Promotion Modules

The course "Health Promotion for Public Health" has been part of the postgraduate programme of the UWC SOPH since its inception. The course subscribes to the goals of SOPH:

> *…to contribute to developing policy-makers and implementers who are knowledgeable and skilled in the principles and practice of public health, whose practice is based on research, influenced by informed and active communities, and implemented with a commitment to equity, social justice and human dignity*.

The course is offered as a module at Postgraduate Diploma in Public Health (120 credits) level and Health Promotion for Public Health II for the Master of Public Health (180 credits) level.

The difference between the modules at the two levels is that at MPH level, the content, although similar to the PGD level, has more depth and requires more critical thinking and analysis. Both are offered as a semester module in which students need to complete certain tasks set out throughout the module guide and partake in discussion forums with their fellow students as they work through the module. The submission of assignments serves as summative assessment.

The following health promotion elective modules were also offered in previous years as part of the MPH:

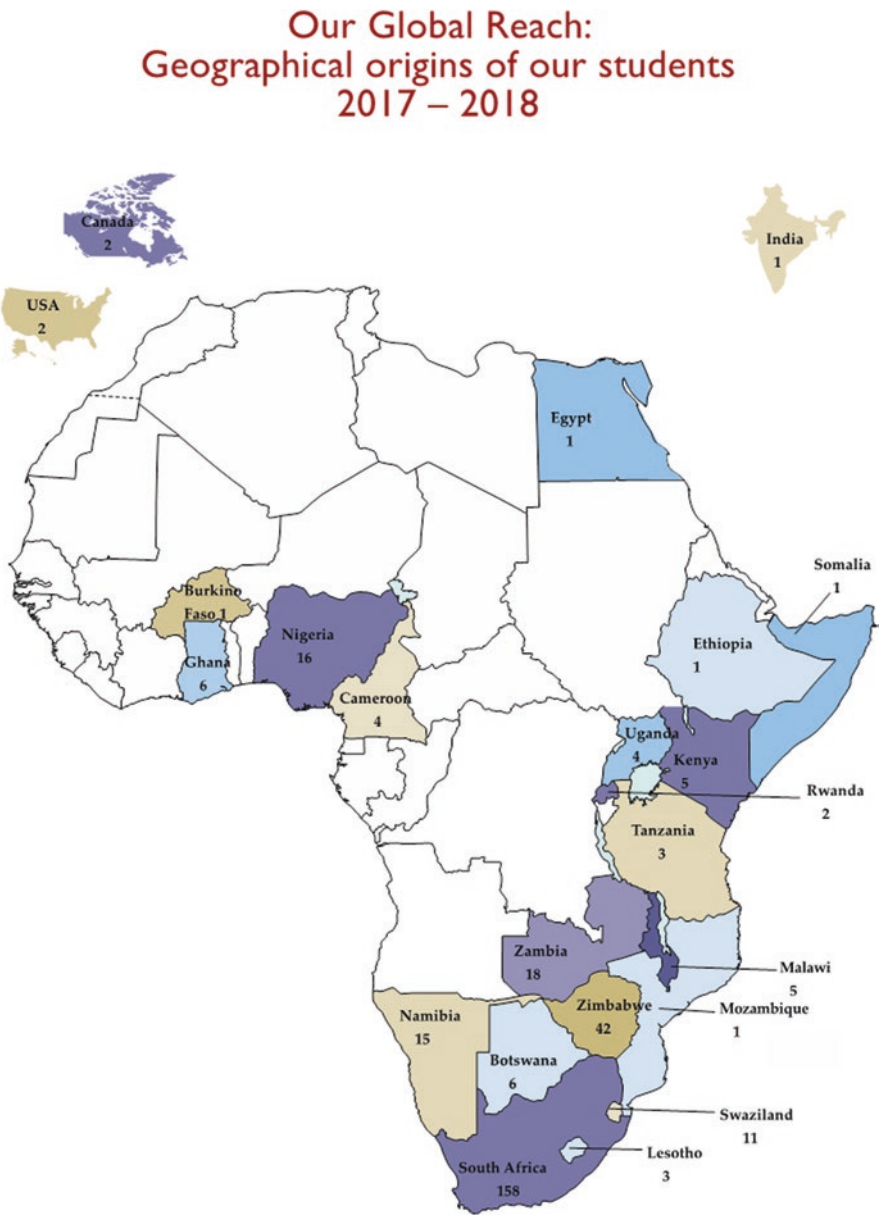

Fig. 7.1 Geographical location of UWC SOPH students for 2017 and 2018. (Source: SOPH annual report, 2017/2018)

- Health Promoting Schools: Putting Vision into Practice
- Health Promoting Settings: A Partnership Approach to Health Promotion
- Alcohol Problems: A Health Promotion Approach

Unfortunately, these electives are currently not offered as module convenors are not available. However, a revision of the Health Promoting Settings module is being planned with a focus on Healthy Cities, which will also include aspects of the Health Promoting Schools module offered as an elective for students.

Health Promotion Teaching and Learning

Since its inception, SOPH realised that teaching health practitioners and members of civil society organisations, most of whom are mature adults, required an approach that would facilitate the ways in which they learn. In his book *The Modern Practice of Adult Education: From Pedagogy to Andragogy*, adult education theorist Malcolm Knowles (1980) popularised the concept of "andragogy", which he defined as "the art and science of helping adults learn". According to Knowles (1984), adult learners tend to be more self-directed and task or goal-oriented than traditional students; therefore, it is important to frame learning strategies in a way that allows them to see the benefits as directly relating to their academic career and work (see two examples of why our students want to study public health in Box 7.2). We use the six principles of adult learning identified by Knowles in the teaching and learning process for our Health Promotion course (see Table 7.1).

One approach that has gained traction in higher education institutions is the creation of an authentic learning environment, which is integrated into the adult learning process and draws on real-world examples and activities, enabling students to make connections between theory and professional practice (Pillay, 2017). Even though educators view authentic learning from different perspectives, many believe that exposing students to this type of learning enables them to deal with the messiness of real-life decision-making required in the workplace (Smith & Parker, 2011). In our teaching and learning process, we apply the nine elements of authentic learning as outlined by Herrington et al. (2010).

Element 1: Provide authentic contexts that reflect the way the knowledge will be used in real life Our course is created around real-world social conditions that have relevance for health promotion interventions, allowing students to actively engage in the learning process. In 2020, the students proposed to discuss COVID-19 as part of the tasks during Zoom sessions. The first task related to the social determinants of COVID-19, while the other task related to types of health promotion approaches that are applied to mitigate the spread of COVID-19.

Element 2: Provide authentic tasks Our students engage in various tasks, which include the following: First, during summer and winter school, students select their own public health topic and develop health promotion programmes centred around

Box 7.2 Examples of Why Our Students Want to Study Public Health

I am a Medical Laboratory Technologist working in the Lesotho Ministry of Health. My responsibilities include diagnosing and monitoring disease processes by examining and analyzing a variety of biological specimens, relay results to clinicians and establish quality assurance programs to monitor and ensure timely, reliable, and accurate results. Studying public health will improve my knowledge in health care and enable me to care for patients especially in vulnerable communities living in remote and mountainous areas.

I am a qualified radiographer/sonographer working at a hospital in a very deep rural area in KwaZulu-Natal. I am a member of a multidisciplinary hospital team. As sonographer I deal with a lot of teenage pregnancies and pregnant women from a disadvantaged background who usually don't have access to healthcare for some reason. I am very excited to study public health as I would really love to focus on health education and health promotion in rural areas in the near future.

issues relevant to their own experiences and/or interests. Furthermore, they work in groups as they would in a real-world situation. Second, students are provided an opportunity to reflect on their own experiences through tasks which are integrated across study sessions in the module guide (see Annex). These tasks are linked to the final assessment which consists of developing a health promotion program using the Ottawa Charter as a framework.

Element 3: Provide access to expert performances and modelling of processes We expose students to a range of experts, including lectures by guest speakers and webinars/seminars. At the summer and winter school, we invite experts to share their experiences on diverse topics, e.g. Health in All Policies; Evaluation in Health Promotion; Communication for Health Promotion programs; Working in Partnerships and Community Participation; Health Promotion Settings; and Advocacy. Most importantly, our course is designed to encourage peer sharing of information, skills and activities.

Table 7.1 The six principles of adult learning used in the health promotion course

Principles of adult learning	How the principle is used in our teaching-learning
Self-concept As people mature, they become less dependent on others and more internally motivated and self-directed. They are able to take responsibility for their own learning	Even though we prepare and provide a study schedule, students are allowed to set their own learning goals
Experience Adults bring life experiences and knowledge to learning experiences	We provide opportunities for students to reflect on their knowledge and experiences and integrate it with what they are learning. At the end of the course, PGD students submit a reflective report, sharing their experiences and observations Students draw on relevant life and work experience as a learning resource. Therefore, we encourage peer discussion and learning Different experiences of students ensure diversity
Relevance Adults need to know why they need to learn something (what the goals or outcomes are)	We provide opportunities for students to identify their learning needs and gaps in their knowledge Through Padlet and during summer and winter school, students share their reasons for learning, e.g. need to know, improve qualifications and to gain practical skills in health services delivery We inform our students from the outset (and constantly remind them) what is expected of them and what they should know, do and value, by the end of the learning experience We are transparent about the learning outcomes and expectations and provide assessment tools and rubrics
Readiness to learn Adults are interested in learning about subjects that have immediate relevance to their jobs or personal lives	Most registered health practitioners are required to earn a specified number of Continuing Professional Development points each year to remain registered with their professional boards Our learning content is relevant to the needs and expectations of students We organise learning and assessment around real-life/authentic tasks that are practical and relevant to their daily work/life
Orientation to learning Adults are interested in learning knowledge and skills for immediate application. They become more problem- and less subject-centred	Our content focuses on real public health issues and is based on authentic, relevant learning Students need to participate in group activities and discussion forums which require problem-solving and application of health promotion concepts
Motivation to learn Adults are more motivated by internal rather than external incentives, e.g. by the need for self-esteem, recognition, better quality of life/work, self-confidence and self-actualisation	We use self- and peer evaluation and other relevant assessment methods to help students reflect on what they are learning and to reinforce internal motivation We provide comprehensive feedback timeously

Element 4: Provide multiple roles and perspectives Our authentic tasks provide students with an opportunity to examine public health topics from different perspectives. Working in group during summer and winter school is a way of encouraging this. In addition, students are encouraged to rotate roles such as being a scribe or presenter, subsequently improving their skills, confidence and preparedness in real-world settings.

Element 5: Support collaborative construction of knowledge Group diversity in terms of knowledge and experience contribute positively to the learning process. We encourage students to constructively comment on other groups' presentations. Students also post reflective commentaries on discussion forums.

Element 6: Promote reflection There are various activities built into the course to promote reflection (see Box 7.3). For example, students reflect on their context and engage with peers. For PGD, students are expected to write a reflective report. We encourage them to take notes in a study diary reflecting on how they applied learn-

Box 7.3 Instructions for Discussion Forum: Analysing Health Promotion projects in terms of the Ottawa Charter

This Discussion Forum is designed to help you engage with the Module guide and prepare for Assignment 2. It is about the application of the Ottawa Charter action areas and strategies in Health Promotion projects. We hope that you will find this a comfortable space to engage with your colleagues, share ideas and learn constructively. One of the principles of adult education is that active participation stimulates greater learning.

You are expected to engage in critical reflective practice.

Part I: Reflecting and learning on your own post

(a) List which action areas and strategies have been employed in each of the readings.
(b) Explain briefly why you have classified them in this way.
(c) Think about one project in your own context, and analyse and classify it in the same way.

Part II: Reflecting and learning by engaging with peers

Read through your colleagues' posts and choose at least two posts (name two colleagues so that we can see which posts you are referring to), and explain why you have found them particularly interesting and/or how they have challenged your thinking in Health Promotion. Please use this space constructively. After this, you are encouraged to continue to engage so that a dialogue develops with your colleagues. You are welcome to do a number of posts, but we expect you to do at least one post in Part I (i.e. your responses to the three questions) and one for Part II (your engagement with two other colleagues in the class).

ing to their work and life experiences and how learning changed their thoughts and behaviour. At the end of the module, students submit their reports, and lecturers provide feedback.

Element 7: Promote articulation to enable tacit knowledge to be made explicit Authentic tasks create opportunities for students to "present and defend their arguments in appropriate forums" (Herrington et al., 2010). Working in groups allow students to talk to each other and, in doing so, explain public health and health promotion concepts to the group. In addition, the online discussion and group sessions provide opportunities for students to present their ideas and to debate and defend arguments. Consequently, students also develop and improve their presentation and writing skills.

Element 8: Provide coaching and scaffolding by the teacher at critical times The distance learning programme is supported by an integrated online Learning Management System (iKamva), which offers various educational technologies to facilitate interactive engagement between students and convenors, including asynchronous online discussion forums as well as synchronous chat rooms. The module guides, readings and additional resources are uploaded onto the system. Students also submit their assignments and receive feedback from the lecturers on the same system. In addition, Zoom online sessions are used to give feedback. These sessions are organised in view of COVID-19 which has dramatically changed the higher education system, including at SOPH. The blended online learning strategy is considered the most practical method to adapt to a new way of teaching and learning as it combines the advantages of synchronous and asynchronous strategies. As a result, there is a transition from face-to-face summer and winter school to online learning. We use synchronous meetings in a virtual classroom using video communication platforms such as Zoom and Google Meet. For group activities, we use Google Jamboard because it allows students to collaborate using a virtual whiteboard. To further improve engagement during online sessions, we use web-based applications such as Mentimeter for synchronous activities, such as polls (e.g. choosing and voting for a health issue for group work) and questions that need real-time input (e.g. what are your expectations of the week?).

Element 9: Provide authentic assessment of learning within the tasks Our authentic assessment of learning is embedded into the course where students are assessed throughout the course and receive feedback on tasks completed and submitted. We use the revised Bloom's taxonomy (Anderson et al., 2001) of cognitive skills to assess academic literacy skills (see Fig. 7.2). During winter school, students and participants receive certificates and Continued Professional Development points.

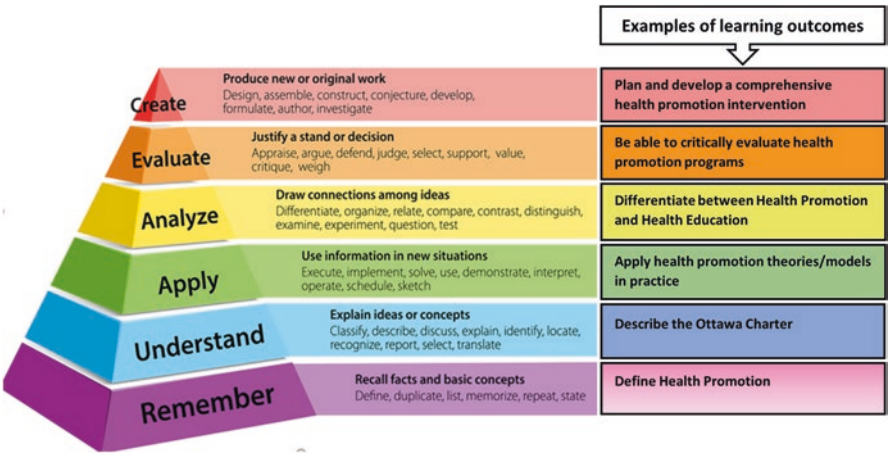

Fig. 7.2 Revised Bloom's taxonomy of cognitive skills and examples of learning outcomes

Formative and Summative Assessment

There are formative and summative assessments for each module. Rubrics for the two assignments are based on the learning outcomes and are shared with the students (see Annex). The formative assessment is the first assignment that students do to assess their understanding of health promotion concepts. The marking criteria for the first assignment are based on four areas, namely, (a) showing the understanding of theories and concepts underlying health promotion; (b) evidence of applying these concepts to address a specific health topic; (c) critical analysis by giving the strengths and limitations; and (c) academic rigour. It is recommended that students submit a draft to allow feedback before submitting their final assignments. If a student obtains a mark of less than 50% for the first assignment, he/she may rewrite this assignment once. Students must attain at least 50% to proceed to the second assignment.

The summative assessment, which is the second assignment, assesses students' ability to operationalise health promotion theory and concepts. In the summative assessment, it is also recommended that students should submit a draft. Students must obtain at least 50% in their final assignment to pass. No rewrites are given for the summative assignment. However, in 2020, the UWC Senate amended the assessment rules, and students who obtained less than 45% of the summative assignment qualified for supplementary examination, viz. a resubmission of their second assignment. PGD students are also assessed through ePortfolio assessment. A complete ePortfolio contains six module reflections including the Health Promotion module.

In Fig. 7.3, we present the 5-year throughput between 2016 and 2020. The pass rate for PGD students ranged from a low of 68% to a high of 98% and for MPH students from 78% to 98%. Students may query their results if they fail a final

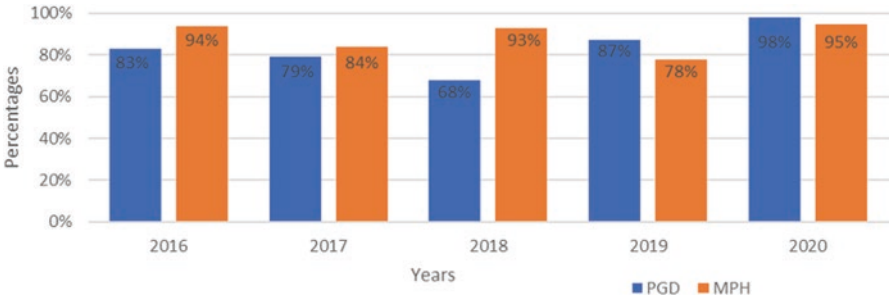

Fig. 7.3 Health Promotion pass rate (2016–2020). (Source: Creation of authors)

assignment, in which case another SOPH staff member will moderate the result. If the student is still not satisfied, the assignment will be reassessed by the external examiner. All summative assessments are moderated by external moderators.

One of the challenges faced by students of the SOPH module on health promotion is time management, as they must juggle work, spending time with family and studying. The programme offers flexibility by providing the opportunity to extend deadlines for submission of assignments within a reasonable time. Although students have become more digitally literate over the years, Internet access for online teaching and learning remains a challenge. The South Africa Government has negotiated with leading mobile network operators to zero-rate institutional Learning Management Systems (incl. iKamva) for as long as lockdown restrictions are in place. However, this differs from other African countries, and some students fail to attend online sessions or submit assignments. A third challenge linked to online learning is the lack of communication when students do not understand parts of the module content or what is required of them, sometimes resulting in poor outcomes. Students are encouraged to communicate via email, telephone, WhatsApp, Zoom, Google Meet, Skype or face-to-face whenever possible. Finally, academic rigour remains a challenge for assessment. Even though UWC offers full digital library services with a plethora of easily accessible online scholarly articles and e-books, students' assignments generally lack engagement with the academic literature. There are also challenges with language, scholarly presentation and inconsistent referencing. We however encourage students to improve their academic rigour by commenting on errors in our feedback, referring them to appropriate resources, and also by allocating marks for it.

Competency-Based Approach

The action areas and principles of the Ottawa Charter form the basis for teaching and learning health promotion in the SOPH curriculum. These action areas (healthy public policy, environments, skills development, health services reorientation and

community outreach) also constitute themes of global health promotion conferences and are aligned with global health topics, such as the social determinants of health and the Millennium and Sustainable Development Goals. Importantly, current issues (e.g. HIV, adolescent health, non-communicable diseases) are used as subjects for module assignments to put theory into practice, which is a crucial aspect of teaching and learning health promotion at the SOPH as outlined above.

The course is known for its practice-oriented approach and its strong focus on strengthening health promotion competencies. This focus was illustrated by a round table organised in 2014 at the SOPH, which gathered stakeholders from academia, government and civil society working in the field of health promotion. The aim of the round table was to reflect, and initiate discussion, on core health promotion competencies for South Africa, which was urgently needed (Onya, 2009). The discussion was informed by a mapping exercise on existing health promotion training curricula in South Africa that assessed the type and level of training, its target audience, format and content. Higher-education institutions were found to offer academic training, but short courses for practitioners were also made available by academic institutions for the benefit of government and civil society.

The round table raised the need to match training with the skills needed in practice, as well as the need for standardisation of health promotion, intersectoral collaboration and integration of health promotion in the training of different occupational groups. Also highlighted was the need to focus on the values of health promotion and skills development required for advocacy. A plea was made to develop training programs in partnership with civil society and strengthen service learning to upgrade existing cadres of practitioners. Participants agreed that health promotion as a profession should be guided by job descriptions and based on acquisition of competencies in line with the level of practice. Curricula should be developed for practitioners in different categories and linked to NQF entry levels into the profession, and training should also be developed outside academic settings and based on real community needs.

Recommendations from this round table were submitted to a Ministerial task team that established the scope of practice for entry-level health promoters to join ward-based outreach teams in view of the re-engineering of the Primary Healthcare (PHC) strategy in South Africa (Onya, 2015). In addition, health promotion qualifications are now accredited by the Health Professional Council of South Africa (HPCSA), a development that was long anticipated and has strengthened the professional identity and credibility of health promotion as a discipline in South Africa.

Discussion on core health promotion competencies for South Africa was informed by the experience of CompHP, a European Union-funded project implemented between 2009 and 2012, which aimed at developing core health promotion competencies, professional standards and accreditation mechanisms for quality assurance in education, training and practice of health promotion. The project was informed by the different domains of the Galway Consensus Conference Statement (Barry et al., 2009), which were assessed through extensive global consultation, albeit dominated by Western health promotion experts, and resulted in the development of a core competencies framework (see Fig. 7.4) which consists of eleven

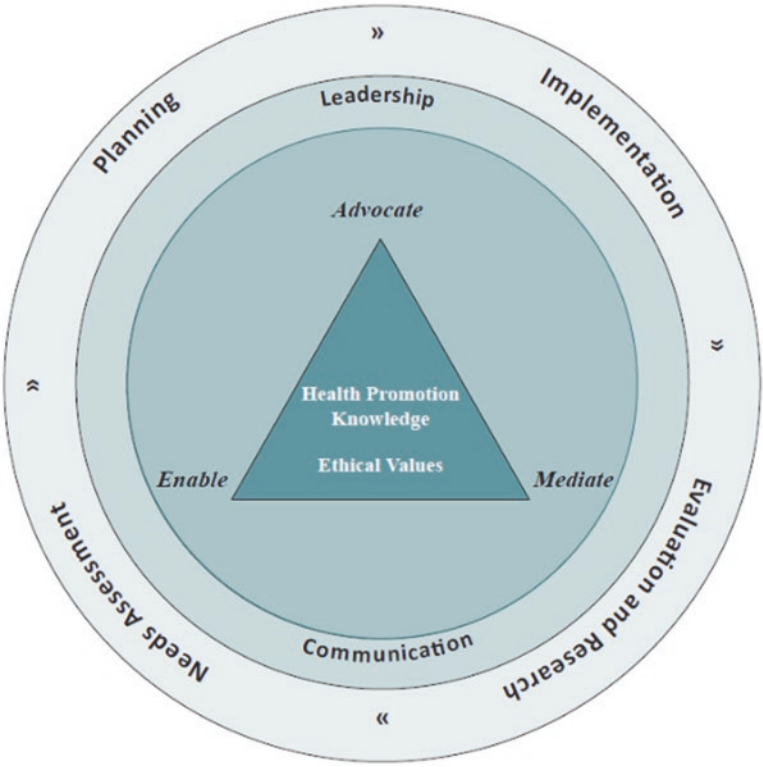

Fig. 7.4 The CompHP core competencies framework for health promotion. (Source: Barry et al., 2012)

domains, including the three health promotion strategies; project cycle management skills; leadership and communication; and a strong knowledge and values base (Barry et al., 2012).

Participants of the round table agreed with the core health competency domains outlined in the CompHP framework and Galway Consensus Conference Statement, focusing on skills development for negotiating partnerships, community-based needs assessment, advocacy and social mobilisation. Due attention was also given to acquiring the needed communication skills and knowledge around the core principles of health promotion. Cultural competency and health literacy were also found to be important, over and above the core competency domains identified in existing frameworks. These findings reinforced the pillars of the health promotion curriculum at the SOPH and were already implemented as part of working with communities and people on the ground (e.g. traditional and religious leaders) and embedded in the approach of working in local partnerships, but were used to further strengthen the teaching and learning in health promotion.

In addition, digital literacy has become an important competency due to the impact of COVID-19 and its impact on remote teaching and learning. The transition to digital literacy was already explored by SOPH through its collaborative work with other universities in sub-Saharan Africa in the years prior to the pandemic, in which emerging opportunities for expanding access to, and delivery of, postgraduate training in public health for people working in or managing health services and systems were explored (SOPH & UWC, 2016). Different distance-based delivery models were assessed, including web-based and e-learning technologies, with a focus on workplace learning and creating authentic learning opportunities for students as outlined above.

Lessons Learnt

The distance learning nature of the curriculum at SOPH makes it accessible to those who want to study health promotion no matter where they are but lack the time or ability to attend classes, either because of work or other commitments. What is useful is that the students can use the experiences from their contexts or countries in their own learning while applying the general concepts and principles of health promotion in daily practice. The experience of distance learning also facilitated the transition to digital literacy years before other programs are now forced to switch from classroom-based contact sessions to online sessions due to COVID-19. Based on a series of workshops held in 2015, and as part of its ongoing work with sister institutions in Africa and the global South, SOPH, for example, developed a set of guidelines for development and design of teaching materials for distance learning (SOPH & UWC, 2016). The implications in terms of assessment, monitoring and evaluation of such programs were also piloted at an earlier stage and crucial lessons learned in terms of how to successfully switch from face-to-face to distance teaching and learning in postgraduate public health education.

Building capacity in public health education for Africa without disrupting health services has also been a tenet of the SOPH since long (Alexander et al., 2009). By focusing on adult and workplace learning, and using materials written in an interactive format applied to common problems encountered by managers and practitioners in daily practice, the opportunity is offered for health professionals to study at a postgraduate level while remaining in post, which is essential to reducing the cost of study for such professionals, as well as for the sustainability of health services (Sanders et al., 2008). Students stand to gain considerably from this pedagogical model, because it facilitates the immediate application of theoretical concepts and models to situations in their real-life work arena (Sanders et al., 2001).

Qualitative evaluation of the postgraduate program at SOPH showed considerable impact at different levels, with graduates being perceived to have gained knowledge and being able to contribute significantly to their workplace and beyond and presenting feelings of enhanced self-efficacy and public health knowledge and skills (Zwanikken et al., 2016). There was also evidence of a shift of focus from a

curative to a more preventive and promotive action in their work, which was corroborated by peers and supervisors. Much of the impact described was hence in line with the aims of training in public health education and health promotion and could inform similar models of postgraduate teaching and learning elsewhere.

Promoting digital transformation is now firmly embedded in African institutions and advocated along a 12-point agenda, which includes transformation and embedding of digital fluency in structural and organisational culture; investing in digital infrastructure/online design competencies; technology-mediated learning modalities; pedagogical changes; twenty-first-century skills; holistic student support; and interventions to address the digital divide (Tiyambe Zeleza & Okanda, 2021). In addition, attention needs to be paid to digital safety and security, the barriers experienced by international students; issues of collaboration and partnership; and research anchored in technological infrastructure. As Zeleza and Okanda correctly point out, this agenda should help transform African universities into active players in digital transformation unleashed by the Fourth Industrial Revolution and accelerated by the COVID-19 pandemic.

Table 7.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 7.2 Authors' reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	Our vision for health promotion is to create a professional and competent workforce with the appropriate skills and knowledge to address the basic social, economic and political causes of ill health through advocacy and lobbying of government and policymakers and includes intersectoral interventions and involvement of various stakeholders at different levels of society including communities themselves
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	The University of the Western Cape (UWC) is well-known for its struggle against apartheid and its continued fight against discrimination and disadvantage in South Africa. UWC has played a key role in the transformation to a democratic dispensation, and one of its primary foci for the future is "to help build an equitable and dynamic society". Apart from disseminating knowledge that is "relevant to the challenges of a modern world and transforming society", it also aspires to be an agent of change. The School of Public Health (SOPH) was established in 1993 as Public Health Programme under the leadership of Prof David Sanders. His legacy is well recognised for his considerable contributions to UWC and the field of public health in general, both locally and internationally. The course module 'Health Promotion for Public Health" has been part of the postgraduate programme of the SOPH since its inception. The module is offered at Postgraduate Diploma in Public Health (PGD) level and for the Master of Public Health (MPH) level

(continued)

Table 7.2 (continued)

Questions	Take-home messages
Which theories and methodologies are used in the teaching-learning process?	Our course module approach is practical, requiring students to relate information to their individual context and reflect on personal experiences as they work through the module. Reflective learning and practice are therefore encouraged where students share their experiences and thereby learn from each other. We use adult learning and authentic learning in our course. A set of academic literacies are applied to all the modules in the programme. Learning outcomes for each module as well as the university's graduate attributes are adhered to. The distance learning programme is supported by an integrated online Learning Management System (iKamva), which offers various educational technologies to facilitate interactive engagement between students and convenors, including asynchronous online discussion forums as well as synchronous chat rooms. The module guides, readings and additional resources are uploaded onto the system. Students also submit their assignments and receive feedback from the lecturers on the same system. In addition, the Zoom online sessions are used to give feedback
What kind of forms of assessment are applied, results achieved and challenges faced?	There are formative and summative assessments for each level. Rubrics for the two assignments are based on the learning outcomes and are shared with the students. The formative assessment is the first assignment that students do to assess their understanding of health promotion concepts. One of the challenges faced by students of the SOPH module on health promotion is time management, as they must juggle work, spending time with family and studying. Although students have become more digitally literate over the years, internet access for online teaching and learning remains a challenge. A third challenge linked to online learning is lack of communication when students do not understand parts of the module content or what is required of them, sometimes resulting in poor outcomes. Students are encouraged to communicate via email, telephone, WhatsApp, Zoom, Google Meet, Skype, or face-to-face whenever possible. Finally, academic rigour remains a challenge for assessment
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	The action areas and principles of the Ottawa Charter form the basis for teaching and learning health promotion in the SOPH curriculum. These action areas also constitute themes of global health promotion conferences and are aligned with global health topics, such as the social determinants of health and the Millennium and Sustainable Development Goals. Importantly, current issues (e.g. HIV, adolescent health, non-communicable diseases) are used as subject for module assignments to put theory into practice, which is a crucial aspect of teaching and learning health promotion. The course is known for its practice-oriented approach and its strong focus on strengthening health promotion competencies. This focus was illustrated by a round table organised in 2014 at the SOPH, which gathered stakeholders from academia, government and civil society working in the field of health promotion. The aim of the round table was to reflect, and initiate discussion, on core health promotion competencies for South Africa, which was urgently needed

(continued)

Table 7.2 (continued)

Questions	Take-home messages
What could others learn with your experience? What is localised and what is "generalisable"?	The distance learning nature of the curriculum at SOPH makes it accessible to those who want to study health promotion no matter where they are, but lack the time or ability to attend classes, either because of work or other commitments. What is useful is that the students can use the experiences from their contexts or countries in their own learning while applying the general concepts and principles of health promotion in daily practice. The experience of distance learning also facilitated the transition to digital literacy years before other programs are now forced to switch from classroom-based contact sessions to online sessions due to COVID-19 By focusing on adult and workplace learning, and using materials written in an interactive format applied to common problems encountered by managers and practitioners in daily practice, the opportunity is offered for health professionals to study at a postgraduate level while remaining in post, which is essential to reducing the cost of study for such professionals, as well as for the sustainability of health services

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Chapter 8
The Health Promotion Curriculum: Evolving and Embedding Competencies in Contemporary Courses

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Introduction

Health promotion is generally considered a relatively young field of practice, with its major growth occurring in the latter part of the twentieth century. However, scholars trace its mention in the literature to around 1917 in the United States and describe health-promoting practices in ancient civilisation (Raingruber, 2017; Madsen, 2016). In its modern context, health promotion emerged as a distinct discipline in 1986 from the development of the Ottawa Charter for Health Promotion at the First International Conference on Health Promotion (World Health Organization, 1986). Burgeoning interest led to increasing professionalisation with the establishment of formal institutions, academic programs and scholarship, and developing competencies to ensure priority components of effective health promotion were included in practice, education and training (Battel-Kirk, 2016). Australia has made significant contributions to the health promotion profession and discipline, establishing well-recognised competency frameworks and educating and training practitioners. This chapter presents an overview of competency development in Australia and usage in learning and teaching in Western Australia, with a focus on processes involved in developing and delivering contemporary health promotion courses.

History of Health Promotion in Australia

The advancement of health promotion in Australia followed a similar trajectory to Europe, the United Kingdom, New Zealand and North America, flourishing from the 1980s. The establishment of national frameworks and institutions reflected growing recognition of the role of health promotion as a critical contributor to Australia's health and wellbeing (Smith et al., 2016). For example, in 1985, the federal government's Better Health Commission recommended more attention to the role of health promotion by reorienting health systems towards health promotion, greater intersectoral action and a national health promotion entity (Commonwealth of Australia, 1986).

In 1987, VicHealth (the Victorian Health Promotion Foundation) was established, followed in 1991 by the formation of Healthway (the Western Australian Health Promotion Foundation). Through respective Tobacco Acts, both organisations used (until 1997) taxes on tobacco products to fund tobacco control campaigns and buy out tobacco sponsorship of sport and the arts and ban outdoor tobacco advertising (VicHealth, 2021; Schang et al., 2011; Healthway, 2021; Cordova,

2003). Whilst no longer in operation, foundations were also created in South Australia (Foundation SA) and the ACT (HealthPact) in the 1990s (Howat et al., 2001).

This period also marked a growing interest in the formation of a member-based organisation for health promotion practitioners. In 1985, the Western Australian Professional Health Educators' Association (WAPHEA) was instituted. Subsequently there was interest from across Australia in a nationally representative organisation. This led to national constitution as the Australian Association of Health Promotion Professionals in 1990. In 1999, the Association assumed its current identity as the Australian Health Promotion Association (AHPA®). Jurisdictional Branches were formed, with the first established in Western Australia in 1992. Activities established included national conferences, the Health Promotion Journal of Australia, local and national events, networking opportunities, mentoring, advocacy and partnerships, state-based Health Promotion Scholarships, Aboriginal and Torres Strait Islander Health Promotion Committee, Thinker in Residence, Health Promotion Ethics Project and Professionalising Health Promotion Project. In 2020, AHPA celebrated its 30th anniversary and enduring contribution to a healthy, equitable Australia and advancement of health promotion as a critical discipline and profession (Howat et al., 2001; Blackford et al., 2022; Crawford et al., 2019; Jones-Roberts et al., 2014; Australian Health Promotion Association, 2021).

Australian health promotion competency frameworks were developed in the late 1990s and early 2000s, which later informed the International Union for Health Promotion and Education (IUHPE) Core Competencies and Professional Standards for Health Promotion (Competencies and Standards) (International Union for Health Promotion and Education, 2016) used globally. Health promotion learning and teaching evolved alongside the development of the health promotion competencies in Australia, particularly Western Australia, with national leadership emerging from teaching and research academics at Curtin University, a large metropolitan University, in the 1980s.

Australian Health Promotion Competencies

Early identification of Australian health promotion competencies was undertaken from 1989 to 1991 by the first university-based health promotion research centre in Australia, Curtin University's Centre for Health Promotion Research (later the Western Australian Centre for Health Promotion Research and now the Collaboration for Evidence, Research and Impact in Public Health). Their initial work was informed by the health education competencies identified in the United States in the early 1980s (Henderson & McIntosh, 1981; National Task Force on the Preparation & Practice of Health Educators, 1985). New South Wales developed initial competency frameworks in the early 1990s, which provided some guidance for best-practice health promotion practice (NSW Health, 1994).

Concurrently, a competency project was being undertaken in Western Australia (van Asselt et al., 1994; Howat et al., 1994). In 1996, Australia's National Health and Medical Research Council reviewed health workforce infrastructure recommending a more comprehensive approach to workforce development in health promotion due to the identification of relatively limited capabilities for health promotion in the overall public health workforce (National Health and Medical Research Council, 1996; Howat et al., 2001). Towards the end of the 1990s, the National Public Health Partnership (NPHP) formed a Health Promotion workforce group with AHPA to develop recommendations on strategic directions for health promotion workforce development (Howat et al., 2001; National Public Health Partnership, 2000).

Recognising the need for unified health promotion professional standards, Howat et al. (2000) commenced a project to determine competencies required for those working in health promotion. Working with the Public Health Association of Australia, the National Heart Foundation and the Health Department of Western Australia, a modified Delphi process and workshops with practitioners developed 63 health promotion competencies. Competencies were grouped into the following categories: needs assessment, planning, implementation, communication, knowledge, organisation and management, evaluation and use of technology (Howat et al., 2000). These competencies informed the development of the Australian national competencies in the early 2000s (Shilton et al., 2001, 2003, 2008a, b), subsequently revised to become the Core Competencies for Health Promotion Practitioners in 2009 (Australian Health Promotion Association, 2009).

Competencies relevant to European countries were concurrently developed, and together with the Australian competencies, they informed the 2008 Galway Consensus Conference (the international collaboration on the development of core competencies) (Barry et al., 2009; Shilton, 2009) and the resulting IUHPE Core Competencies and Professional Standards for Health Promotion (Dempsey et al., 2011). Since 2012, the discipline of health promotion has been strengthened by introduction of the IUHPE European Health Promotion Accreditation System, which sets international competency and accreditation standards (Battel-Kirk, 2016) and has had strong uptake in Australia. To date, five universities across Australia have received accreditation from IUHPE for undergraduate and postgraduate health promotion courses; and IUHPE has endorsed AHPA® to manage the individual health promotion practitioner registration via their National Accreditation Organisation.

The History of Health Promotion Learning and Teaching in Western Australia

Curtin University is a pioneer in health promotion education in Australia. In 1980, Curtin University first offered health promotion as a specialist area at the postgraduate diploma level. This 1-year full-time course could be undertaken part-time and was offered in the evenings to accommodate full-time employees. The

diploma-level course educated Australia's first health promotion practitioners who were graduates of related degrees (e.g. health and physical education teachers, nurses, allied health professionals). Additionally, the course also met the requirements of the first year of a Master of Health Sciences. Also in 1980, an undergraduate health promotion unit was embedded for the first time within the health science degree. A specialisation in health promotion (comprising several units) was offered in a Bachelor of Health Sciences degree in 1984. A full 3-year Bachelor of Science (Health Promotion) (BSc Health Promotion) was first offered in 1987 and was available later by distance learning.

Alongside its health promotion teaching program, Curtin staff fostered a program of health promotion research, providing students with contemporary learning experiences and evidence-informed knowledge and skills through the teaching-research nexus. The team contributed to the development of health promotion scholarship around health promotion concepts and definitions (Howat et al., 2003). Higher degrees were offered from the 1980s via a Master of Health Sciences and a Doctor of Philosophy providing a range of health promotion research opportunities. In 1986, Curtin University established the first university-based health promotion research centre in Australia, the WA Centre for Health Promotion Research (CHPR) (later named WACHPR). Now the Collaboration for Evidence, Research and Impact in Public Health (CERIPH), the centre houses a multidisciplinary research team within the Curtin School of Population Health.

In 1989, a grant from the Australian Federal Government enabled the development of the postgraduate diploma as the first health promotion distance-learning course, providing capacity for delivery throughout Australia. Learning materials would arrive by post in heavy envelopes full of bespoke written modules, audio tapes, photocopied readings and assignment information. Completed assignments were posted to the university, marked and posted back to students. Lecturers were available to students for telephone appointments. Health promotion higher degree by research opportunities via a Master of Philosophy and a Doctor of Philosophy have been offered since the 1980s.

Through the 1990s, Curtin University developed the most extensive range of health promotion courses in the southern hemisphere. Courses were offered face to face and by distance learning (Howat et al., 2000). The initial offering of a Postgraduate Diploma in Health Promotion was extended to include a Master of Health Promotion and a Master of Health Communication with a 'nested' Graduate Certificate in Health Promotion. The Master of Public Health offered a health promotion major. Postgraduate enrolments peaked during this time period, reflecting the growth and recognition of health promotion as a professional discipline, and practitioners and professionals in related professions pursuing formal health promotion qualifications. The availability of courses via distance learning facilitated this growth and the concomitant rise in graduate employment in health departments and non-government organisations.

As the health promotion profession matured in Western Australia with increasing numbers of practitioners with postgraduate qualifications, attention turned to expanding Curtin University's undergraduate course offerings in the early 2000s. A 4-year honours degree and 4-year double degree were offered, the double degree

combining health promotion with a complementary degree (i.e. nutrition, workplace health and safety, Asian studies, business and humanities). During this time, paper-based distance education units were transformed to be offered fully online, with all courses available to domestic students worldwide.

Mapping Early Australian Competencies to Curtin Health Promotion Courses

Curtin health promotion courses were the first in Australia to map and embed health promotion competencies into the curriculum. The 63 competencies established in the early Australian competency framework (Howat et al., 2000) and the subsequent reviews influenced all Curtin health promotion course developments. In 1994, after the initial competency identification, undergraduate and postgraduate courses were reviewed. All units were assessed to determine its contribution to student development of health promotion competencies (Maycock et al., 2004; Howat et al., 2000).

Maycock et al. (2004) described the process which involved mapping competencies, identifying gaps, gathering feedback from students and recent graduate and seeking advice from health promotion practitioners working in industry. This was the first time such a comprehensive course competency mapping process had been undertaken in Australia. It resulted in the explicit linking of competencies to unit content; development of new units; refinement of existing units; changes to unit sequencing to enhance scaffolded competency attainment; an emphasis on competency development via fieldwork; and a focus on skill attainment via interactive case studies and problem-based learning (Maycock et al., 2004). This course review has continued on an annual basis with additional competency feedback provided at Advisory Board and unit-specific meetings from major Western Australian employers of health promotion practitioners. Activity explicitly fostered reflective practice, and students recorded competency development in a personal portfolio (Maycock et al., 2004; Howat et al., 2000).

In 2002, the portfolio process was formalised, and students began to document and map their own competency development as they moved through the course (Hazell et al., 2004; Maycock et al., 2004). The ‘evidence guide’ used by students to document their competency attainment was developed through consultation with the vocational training sector (Hazell et al., 2004). This evidence guide was conceptualised as a planning tool for students, to assist graduates present skills to future employers (Hazell et al., 2004).

Evolution of Curriculum

Health promotion courses at Curtin University have been through numerous iterations since the 1980s. Continuous curriculum review and re-development have maintained contemporary courses closely aligned with health promotion

competency developments. This section presents an overview of the latest BSc Health Promotion (the Course) review as a case study.

Course Overview

The present Course is a 3-year (six semester) undergraduate coursework program aimed at students who want to develop the knowledge and skills for addressing health issues and promoting health. Students learn how to identify the health needs of individuals, groups and communities, and plan, implement and evaluate health promotion interventions incorporating a range of strategies including community development, advocacy, social marketing, healthy public policy and environmental supports. The curriculum is designed to foster graduates who possess the skills, knowledge, values and ethics required for health promotion practice (whether in service delivery, research or policy) as outlined in the Competencies and Standards.

The Course provides a comprehensive program of study, which includes interprofessional learning in the first year, followed by health promotion specialisation in the second and third years. Units offer blended learning (a combination of online and face-to-face learning) and integrate both theoretical and practical elements into learning outcomes. The theoretical content incorporates physical, psychological, political and social sciences to develop a comprehensive understanding of health determinants. The practical elements comprise fieldwork visits, on-campus project implementation and a 100-h professional placement in the final year of study.

In 2016, the Course was the first in Australia to receive accreditation with the IUHPE system. The Course underwent substantial review and renewal in 2019/2020 to better align units with the IUHPE competencies and contemporary health promotion principles, and a new course structure commenced in 2021. The following sections provide an overview of the course review process undertaken by teaching staff, a summary of the key curriculum changes and competency assessment methods embedded in the new course structure.

Course Review Process and Outcomes

In 2019 academic staff undertook a comprehensive review of the Course introduced in 2015 (refer to Table 8.1) to revise alignment with the Competencies and Standards in preparation for re-accreditation in 2021. The course review progressed through three phases:

1. Analytics: Review of course data.
2. Review: Health Promotion Courses Advisory Board meeting; focus group with health promotion students (n=8); video interviews with key industry stakeholders (n = 8); external referencing of standards with a partner university; and workshops (n = 3) with the Health Promotion teaching team.
3. Transformation: Establish new units and transform the course structure.

Table 8.1 Evolution of BSc Health Promotion curriculum between 2002 and 2021

2002	2015	2021
Year 1		
Semester 1		
Emergency Medical Care	Introduction to Public Health	Introduction to Public Health
Health Science Communication		
Health Promotion	Introduction to Psychology	Health Promotion Principles and Values
Human Biology	Foundations for Professional Health Practice	Foundations for Professional Health Practice
Psychology	Foundations of Biostatistics and Epidemiology	Imagining Health in Social and Cultural Contexts
Semester 2		
Alcohol and Other Drugs	Promoting Physical Activity and Injury Prevention	Preventing Non-Communicable Diseases
Epidemiology	Imagining Health in Social and Cultural Contexts	Foundations of Biostatistics and Epidemiology
Human Biology	Human Structure and Function	Human Structure and Function
Psychology	Indigenous Cultures and Health Behaviours	Indigenous Cultures and Health Behaviours
Year 2		
Semester 1		
Injury Control	Alcohol and Other Drugs	Health Promotion, Equity and Social Justice
Mental Health Promotion	Promoting Mental Health and Social Inclusion	Health Promotion Methods
Health Promotion Methods	Health Promotion Planning	Health Promotion Planning
Cancer Control	Cancer Control	Health Care Systems in Australia
Semester 2		
Nutrition and Health	Fundamentals of Public Health Nutrition	Health Promotion, Media and Advocacy
Physical Activity and Health	Health Promotion in Action	Health Promotion in Action
Professional Practice (Health Promotion)	Health Promotion Methods	Promoting Mental Health and Social Inclusion
Epidemiology	Introduction to Epidemiology	Epidemiology – From Principles to Practice
Year 3		
Semester 1		
Health Promotion Methods	Health Promotion in Challenging Contexts	Health Promotion in Challenging Contexts
Health Promotion Planning	Evidence and Effectiveness in Health Promotion	Evidence and Effectiveness in Health Promotion

(continued)

Table 8.1 (continued)

2002	2015	2021
Professional Practice (Health Promotion)	Professional Practice in Public Health	Professional Practice in Public Health
Option	Applied Research and Biostatistics	Applied Research and Biostatistics
Semester 2		
Evaluation of Health Promotion	Health Promotion, Media and Advocacy	Applied Public Health Practice
Health Promotion and the Media	Health Promotion Leadership and Identity	Health Promotion Leadership and Identity
Settings in Health Promotion	Health Partnerships, Politics and Power	Health Partnerships, Politics and Power
Professional Practice (Health Promotion) Or Research Project	Option	Global Public and Planetary Health

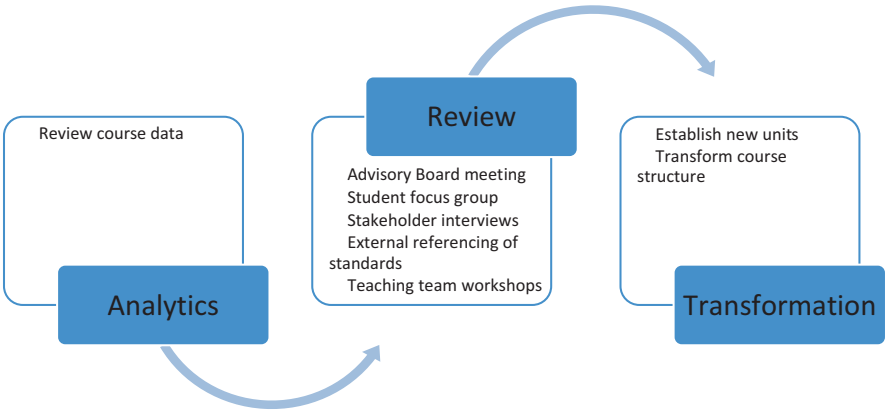

Fig. 8.1 BSc Health Promotion course review process

Figure 8.1 provides an overview of the full comprehensive course review process, with each data input explained below.

Health Promotion Courses Advisory Board

Part of the course review process involved engaging with the Curtin Health Promotion Advisory Board (the Advisory Board). The Advisory Board is a representative, consultative body comprising relevant University staff and representatives from industry, government, the community and professional associations. The Advisory Board advises on changing trends, needs and priorities relating to Health

Promotion; develops links with industry, government and the community; contributes to the general promotion of the discipline; and considers new courses and course review changes and accreditation.

Feedback from the Advisory Board on the course structure indicated that a revised course would require a stronger focus on commercial and political determinants; rural content and geographical perspectives; the Sustainable Development Goals; community development; global perspectives; and partnerships across sectors. In addition, more specific health promotion content in the first year of the course was welcomed. This feedback was reviewed during subsequent teaching team workshops.

Student Focus Group

Feedback was sought from final-year students (n=8) via a focus group. Students were asked about their impressions of the Course, their identity as health promotion students, feedback on practical activities and placements and suggestions for improving the Course. Students provided the following feedback: a need for further opportunities to engage in practical activities throughout the course; some units are fun but too simple and repetitive (e.g. content-focused units); certain concepts need to be introduced earlier in the course rather than being left until the final year (e.g. intersectionality; paternalism; healthism); and knowledge and skills related to health promotion identity need to be introduced earlier in the course. Data from the focus groups informed staff workshops.

Stakeholder Interviews

In-depth interviews were conducted with industry stakeholders (n = 8) to gather course feedback and recommendations to improve the curriculum, which were considered in subsequent teaching staff workshops. Three groups of stakeholders were defined for the consultation exercise: (i) academics teaching into health promotion courses in Australia; (ii) members of the AHPA® National Accreditation Organisation and IUHPE accreditation committees; and (iii) health promotion practitioners and managers working with health promotion graduates. Stakeholders were asked about their views on emerging issues and challenges for health promotion, ideal practitioner attributes for addressing key challenges and suggestions for improving placements and practical opportunities for students.

Stakeholders identified the following future issues and challenges for health promotion: partnerships across sectors; equity; climate and health co-benefits; ageing population; and health promotion identity and workforce. The following practitioner attributes were suggested as vital to address these key challenges: a solid understanding of the need for a comprehensive approach to interventions; data analysis

skills; theoretical knowledge; an ability to work in a multidisciplinary team; strong advocacy skills; an understanding of the health sector; cultural awareness; and critical thinking and reflection skills. Stakeholders suggested that placements and practical opportunities should be provided earlier in the course and have a stronger focus on cultural immersion; and there should be longer placements or more throughout the course. In addition, students should be offered greater variety in placements and host organisations throughout their course.

External Referencing of Standards

External referencing of standards was undertaken with a partner university offering a similar undergraduate course. Examples of final-year student assessments were reviewed by staff at the partner university, with a focus on standard of work, scope of task and relationship to health promotion competencies. Assessment tasks clearly aligned with the relevant graduate attributes for the unit and health promotion competencies; and the overall student achievement standards were met satisfactorily.

Workshops with Teaching Staff

Three workshops were conducted with health promotion teaching staff during the review process. The focus of Workshop 1 was to review the 2015 course structure mapping against the Competencies and Standards; analyse student focus group data; review feedback from the Advisory Board; and review course and unit performance data. This information was used to conduct a Strengths, Weaknesses, Opportunities, Threats (SWOT) analysis for the Course (see Fig. 8.2) and to generate initial ideas for changes to the course structure and individual units.

The review's main focus was to scrutinise all unit syllabi, unit learning outcomes and assessments to ensure relevancy and currency for industry needs, based on inputs from the review phases. After triangulation of data during the review process, teaching staff developed a new course structure and proposed revisions to individual units during Workshop 2. Workshop 3 finalised new unit titles, syllabi and unit learning outcomes and developed an implementation plan for the course. A summary of the key course changes is provided in the next section.

Summary of Course Changes

The Competencies and Standards provided a benchmark for the Course to maintain its accreditation, ensuring students graduate having achieved the expected graduate attributes as set by IUHPE. The latest course review included careful mapping and

Strengths	*Weaknesses*
• Accredited by IUHPE • Practical components of the course create job-ready graduates • Good reputation of the program among industry • Strong history of health promotion at Curtin – considered a leader within WA and Australia • Teaching staff involved in health promotion both nationally and internationally – e.g. three staff are AHPA® Board members • Flexibility/agility of staff • Course is fully online • Sound enrolment base	• Lack of marketing, particularly to east coast prospective students • Compression of health promotion content due to interprofessional first-year curriculum constraints • Difficulty obtaining accurate course data • Insufficient workload allocation to adapt to new innovations to online content
Opportunities	*Threats*

• Marketing opportunities:
  ○ Students undertaking Health Studies in their final 2 years of high school
  ○ Mature age market
  ○ Other fields needing health promotion skills
• Course delivery at offshore campuses
• Professionalisation of health promotion workforce more broadly makes Curtin course a leader – potential marketing/recruitment opportunity
• Additional double degrees could be created outside of the School of Population Health e.g. other faculties
• Stackable degrees combining undergraduate health promotion with a postgraduate component could be created
	• Importance/value of health promotion within public health and beyond poorly understood
	• University-wide pressure to cut units and availabilities presents challenges for accreditation needs and best practice

Fig. 8.2 SWOT analysis of the BSc Health Promotion course

consideration of these competencies throughout the review process, to ensure units meet these requirements. A review of unit sequencing, content, assessments and pre- and co-requisites was part of the review process.

To support current and emerging local and global challenges to health promotion, along with new global targets and new theory, individual units were revised and updated to provide a more contemporary experience for students. Key course changes included:

- Re-mapping against the Competencies and Standards to ensure graduates have the opportunity to meet the requirements of contemporary health promotion practice
- A greater focus on concepts (e.g. equity, social justice, social inclusion) rather than specific content areas (e.g. alcohol and other drugs, cancer, physical activity)

- The introduction of a first-year health promotion principles and values unit to strengthen the health promotion identity of students throughout the course
- A stronger focus on planetary health, climate change and new global directions such as the Sustainable Development Goals
- Enhanced leadership and global citizenship content, with professional partner links strengthened by the new structure that incorporates a capstone practice experience
- Increased work-integrated learning and practical opportunities throughout the course
- Improvements in online learning delivery to meet the needs of wholly online learners

These changes are reflected in the evolution of the Course curriculum from 2002 to 2021 (Table 8.1). Outcomes of the most recent review are represented by the changes from 2015 to 2021 as shown in Table 8.1.

A significant change to the Course since 2002 is Indigenisation of the curriculum. This is a vital step in 'closing the gap' between the life expectancy and health outcomes between Indigenous and non-Indigenous Australians (Lowitja Institute, 2021). Since 2011, all students enrolled in Curtin University's Faculty of Health Sciences (which includes Health Promotion) complete a specialised Indigenous cultures and health unit in their first year of study. This unit is predominantly managed and co-taught by Aboriginal and Torres Strait Islander staff. Additionally, students can develop intercultural awareness and global perspectives through assignment choices, case studies, fieldwork placements and Indigenous cultural advisers and health practitioners who provide guest lectures and interactive sessions for students in several units throughout the course. Four of the teaching staff have completed the Cultural Awareness Program with Curtin's Elder in Residence, Wadjuk Noongar Elder Professor Simon Forrest, three of whom became 'Koordas' ('Friend' in the local Noongar language) in the Faculty of Health Sciences. These staff work closely with the Indigenous Engagement Team within the Faculty of Health Sciences to support and promote Indigenous student engagement. Incorporating Indigenous knowledges and perspectives ensures that students (both Indigenous Australians and non-Indigenous) develop an understanding of culture and diversity within local, national and global Indigenous populations; the impacts of specific policies and historical events on Indigenous Australians; and the effects of these policies on health, illness and disability and healthcare access. The development of cultural competence to enable respectful engagement with local First Nations Peoples and other diverse cultures is a required university-wide graduate capability. Health promotion graduates are further prepared to work in respectful and equal partnership with Indigenous communities to promote health.

Another significant change to the Course has been improvement in the online delivery of units and content. Whilst online and distance education has been available to students for several decades, fully online courses have increasingly incorporated interactive online tutorials, discussions and meetings with the rapid advancement of supporting technologies. Unit Coordinators write dedicated and bespoke Blackboard®

content for online students in addition to the content delivered for internal students during face-to-face teaching. Staff work with the university learning engagement team to create presentations and videos using a green screen equipped video studio and use several tools/platforms to enhance student engagement. Examples include Blackboard Collaborate™, discussion boards, online meetings (group and individual) using videoconferencing and Cisco Webex® for live streaming of presentations, seminars and group discussions. This strong focus on online delivery ensured that Curtin health promotion courses were well placed to respond to the online learning requirements during the COVID-19 pandemic.

Embedding and Assessing Competencies

It is critical to prepare graduates to be globally employable and to monitor students' core competency development by embedding assessment into the curriculum across the 3 years of the BSc Health Promotion course. This section presents an overview of the current methods used to assess student achievement of the Competencies and Standards.

Work-integrated learning is a focus of the Course. Units provide links to diverse opportunities to ensure that students develop the skills necessary for the workplace. The Course incorporates a fieldwork placement that provides students 100 h with an agency or organisation to undertake 'real-world' health promotion action. Additionally, key stakeholders from industry provide guest lectures in many units, and students participate in site visits to key health promotion agencies, authentic assessment and work-integrated learning to mirror workplace tasks. An outcome of the latest course review was introducing an assessment series to enhance health promotion identity and monitor student achievement of the Competencies and Standards across the course. This assessment series is presented in Case Study 1.

Case Study 1: Passport to Practice

The *Passport to Practice* assessment series provides an example of work-integrated learning and authentic assessment. The assessment series examines student development of the Competencies and Standards across the 3 years of the Course. Across three units, students explore their knowledge and skills within each of the nine competency domains and measure the development of global citizenship through course progression.

Students commencing the Course enrol in a unit in their first semester of study which introduces them to the principles and values of health promotion as a theoretical foundation for contemporary practice, policy and research. Students are introduced to the Competencies and Standards and learn about how they form the criteria for practitioner registration and course accreditation. The *Passport* is

introduced as a major assessment piece for the unit. Students are presented with the opportunity to chart their own competence for health promotion through a series of practical and reflective activities relevant to the Competencies and Standards. Students begin by mapping their existing knowledge and skills, followed by developing a plan to participate in practical and reflective activities to enhance their competencies, both inside and outside of the classroom (examples include development of Twitter and LinkedIn profiles for professional networking, cultural awareness and diversity training sessions, volunteering with a range of health promotion organisations and webinars). Teaching staff guide students to select activities that complement the concepts they are learning in the unit, to enhance their existing health promotion knowledge and skills. Students can choose from a list provided or "go their own way" provided they can demonstrate the relevance of their activities to contemporary health promotion practice as articulated in the Course.

Part of the assessment involves future gazing, whereby students plan for further competency development in subsequent years. Students build on this assessment in their second year of study, which provides students with a practical introduction to the health promotion cycle and teamwork, followed by a capstone unit in their final semester of study, focusing on developing leadership skills and reinforcing their sense of identity. Students are required to accumulate additional activities for their *Passport* in each of these units, which builds upon the previous year of practical and reflective activities. Activities include speechmaking, study tours, advocacy submissions and a range of research activities. As a culminating activity in the final year, students undertake a series of assessment designed to test a mature grasp of competencies, including through oral defence of health promotion concepts and their understanding of how the Competencies and Standards form the basis of the profession and discipline. They assume the identity of a health promotion practitioner and engage with peers and teaching staff in a community of practice. Teaching staff look for evidence of improvement in knowledge and skills within each of the nine competency domains across the three units and work collaboratively to ensure activities and assessment are scaffolded and appropriate through regular team reflection and quality improvement.

Through this assessment series, students are introduced to the practice of why and how to demonstrate continued professional development to maintain practitioner registration with IUHPE once they have graduated. This series allows students to put lifelong learning into practice early and demonstrate that they are ready for practice after graduation. Encouraging this practice during university studies prepares graduates to register as IUHPE Registered Health Promotion Practitioners and to update their continuing professional development as required by the IUHPE at regular intervals throughout their career.

Keeping It Contemporary via Industry Links

A vital element of creating and maintaining a current health promotion course is strong links with industry partners. Staff deliver a long-running health promotion short-course face-to-face and online to industry, often in partnership with the Australian Health Promotion Association. The teaching staff at Curtin University are all IUHPE Registered Health Promotion Practitioners with significant experience across health promotion teaching, advocacy, practice and research. Staff undertake research through CERIPH (refer to Case Study 2 for further information) and are members of community committees and special interest groups locally, nationally and internationally. Key groups include AHPA (including the National Accreditation Organisation Assessment Committee); the Health Promotion Journal of Australia; and the IUHPE Southwest Organising Committee. Staff have held current and previous leadership roles with these groups including as President, Board Members, Chairs and Editors. Several staff have been awarded Fellowship and Life membership with AHPA. Diverse backgrounds and industry connections provide significant placement and volunteering opportunities for students. These opportunities enhance the work integrated learning focus of the course and provide additional competency development opportunities beyond the classroom.

Case Study 2: From Classroom to Health Promotion Practitioner

Background

Through CERIPH, academic staff conduct a range of research and capacity building health promotion endeavours, guided by the IUHPE Core Competencies and Professional Standards for Health Promotion. This case study follows Meg – a Bachelor of Science (Health Promotion) undergraduate student – and her journey from final-year professional placement, volunteering and Honours degree to joining the health promotion workforce.

Placement to Honours

Over the past 10 years, researchers from the CERIPH Drowning Prevention, Evidence and Evaluation Project (DEEP) have been working with the Royal Life Saving Society of Western Australia (RLSSWA), exploring issues associated with fatal and non-fatal drowning. Academic staff and industry provide students with opportunities to complete their 100-h professional placement. The unit syllabus requires students to develop and apply discipline-specific knowledge and skills

through a relevant health promotion project experience. CERIPH provides a professional research environment that facilitates the opportunity for students to refine their skills and knowledge in a supportive environment. During her placement with the DEEP team, Meg explored young people's knowledge, attitudes and behaviours related to alcohol consumption and participation in aquatic activity using the Health Belief Model (Hochbaum et al., 1952) as a framework. This placement provided Meg with an opportunity for real-world application of the conceptual knowledge and skills gained through lectures, tutorials and assignments. Meg mapped IUHPE competencies 1, 4, 6, 8 and 9 as part of her placement including writing a proposal (6.2, 6.3), ethical approval processes (6.7), designing a focus group interview guide (8.1), recruiting participants (6.1, 6.3), collecting data by facilitating focus groups (4.1, 4.2, 4.3, 4.4) and writing for publication (1.2, 9.1, 9.5). Meg completed her placement and continued with the DEEP team as a volunteer, working alongside her supervisors to produce her first peer-reviewed publication (Abercromby et al., 2020b). The placement project experience led to an application for the Honours degree.

Honours

Meg was accepted into the Public Health Honours program, researching drowning and water safety factors amongst older adults. The three-stage, mixed-methods (9.1, 9.3, 9.4) Older Adults and Drowning Prevention study was the first of its kind in Western Australia. Whilst there are significant recognised benefits of aquatic activity to preserve life amongst older people, very little is known about the factors influencing drowning or drowning prevention in this age group. Meg used coronial data and in-depth interviews (9.1, 9.4) to explore these factors:

> *I used coronial data to create profiles of those who had drowned in Western Australia. Those who had drowned were mostly males, more than half were born overseas and a large proportion was aged 65–70. From this data, I developed four unique clusters of risk factors. The information helped us better understand how and why these individuals drowned, and we will be able to create more targeted interventions for people with similar characteristics.*

In the third stage, Meg designed and tested an online survey to gather baseline data on older adults in WA (8.2, 9.1). Meg worked with the DEEP team to publish the findings from her Honours study (9.3, 9.5), contributing to the sparse body of literature that addresses drowning prevention in older adults (Abercromby et al., 2020a).

At the end of her studies, Meg said, "My course as a whole was amazing. I learned about real-world issues and innovative ways to tackle the global health promotion priority areas".

Honours to the Workplace

Subsequently, Meg commenced full-time employment at RLSSWA as the Health Promotion, Research and Evaluation Officer. The foundation provided by the accredited IUHPE Course and the relationship between researchers in the DEEP Team (who are also all IUHPE Registered Health Promotion Practitioners) and health promotion practitioners at RLSSWA supported a seamless transition from student to employee. Meg undertakes applied, community-facing research and evaluation to guide the planning and implementation of drowning prevention programs (9.1–9.5 inclusive). Honours degree findings were immediately translated into practice, informing baseline evaluation data collection and creative direction for the state-wide, government-funded 'Make The Right Call' campaign for older adults at risk of drowning (7.1, 7.5, 8.1, 8.2, 8.3) (Royal Life Saving Western Australia, 2021).

Outcomes

Meg continues to build knowledge, skills and abilities translating theory and research into real-world health promotion action to prevent older adults from drowning. Since graduating, she has published two peer-reviewed papers and presented at an international conference. She is the recipient of an Australian Health Promotion Association 'Shooting Star' award, which recognised her contribution to drowning prevention and her emerging leadership in health promotion. Embedding IUHPE standards in the degree constructed a clear pathway from Curtin undergraduate student to the health promotion workforce. The case study demonstrates how capacity building guided by the IUHPE Competencies and Standards during undergraduate studies facilitates qualified and 'work-ready' health promotion graduates.

Conclusion

This chapter presented an overview of the history of health promotion competency development in Australia and learning and teaching in Western Australia, focusing on processes involved in developing and delivering courses to support graduates to respond to meet current and emerging challenges. Curtin University has a strong history of mapping and embedding health promotion competencies into the curriculum. The continuous curriculum review and re-development over three decades has ensured that courses have remained contemporary and closely aligned with national and international developments in health promotion competencies. The experience at Curtin highlights the importance of close engagement between academic staff and industry stakeholders, students and external academic staff during course reviews to ensure that revised units reflect a contemporary approach to health

promotion. The Competencies and Standards provide an essential benchmark for health promotion learning and teaching. Their use ensures that students graduate achieving the expected graduate attributes articulated by IUHPE and equips them to become ethical, knowledgeable and skilled health promotion practitioners.

Table 8.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 8.2 Authors' reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	Krysten: 'Now more than ever we need a strong health promotion workforce to address complex global public health challenges. Health promotion academics have an important role to play, not only in our own practice, but also in training the next generation of practitioners to mediate, enable and advocate for health and social change' Gemma: 'My vision is that we, collectively, fulfil health promotion's promise as radical agent of change for justice, peace and prosperity. I hope that together we can continue to nurture a thriving discipline and profession capable of responding to the challenges that face humanity and the planet' Sharyn: 'A range of educational, environmental, legislative, economic and political strategies are employed to promote positive health ethically and equitably for all population groups. Health promotion should be underpinned by principles of social justice and ethics and recognise the complexity of determinants of health that influence individuals, communities and populations' Jonine: 'For health promotion to continue to grow and be recognised as an innovative science of high expectations and aspirations to improve the health and wellbeing of all people' Justine: 'My vision for health promotion is a true partnership between community members, practitioners, researchers and policy makers to yield innovative, sustainable and diverse actions that are supportive of health and health equity for our most vulnerable communities'
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	Curtin University is a pioneer in health promotion education in Australia. Curtin's BSc Health Promotion course is designed to equip students with the theoretical and practical skills required for a career in health promotion. The curriculum is designed to foster graduates who possess the skills, knowledge, values and ethics required for health promotion practice (whether in service delivery, research or policy). A vital element of creating and maintaining a current health promotion course is strong links with industry partners. The teaching staff at Curtin University are all IUHPE Registered Health Promotion Practitioners with significant experience across health promotion teaching, advocacy, practice and research Course concepts and assessments are underpinned by the IUHPE Core Competencies and Professional Standards for Health Promotion, and scaffolded across the course to encourage competency development and self-reflection from first year onwards. Encouraging this practice during university studies will prepare graduates to register as IUHPE Registered Health Promotion Practitioners and to update their continuing professional development requirements required by the Australian Health Promotion Association and IUHPE at regular intervals throughout their career

(continued)

Table 8.2 (continued)

Questions	Take-home messages
Which theories and methodologies are used in the teaching-learning process?	Our Course encompasses a combination of teaching methods, and all of our units are underpinned by the IUHPE Core Competencies and Professional Standards for Health Promotion. The Course provides a comprehensive program of study, which includes interprofessional learning in the first year, followed by health promotion specialisation in the second and third years. We acknowledge that learning can happen anywhere and at any time and focus on making learning accessible to as many students as possible via methods underpinned by Universal Design for Learning principles. Units offer blended learning (a combination of online and face-to-face learning) and integrate both theoretical and practical elements into learning outcomes. The theoretical content incorporates physical, psychological, political and social sciences to develop a comprehensive understanding of health determinants. The practical elements comprise fieldwork visits, on-campus project implementation and a 100-h professional placement in the final year of study. Experiential learning is incorporated via interactive workshops using a flipped classroom approach to enhance student and staff interaction
What kind of forms of assessment are applied, results achieved and challenges faced?	We use a variety of assessment types including long and short written papers, e-tests, field placements and group work. Work-integrated learning and authentic assessment are fundamental to the Course. Units provide links to diverse opportunities to ensure that students develop the skills necessary for the workplace. The Course incorporates a fieldwork placement that provides students 100 h with an agency or organisation to undertake 'real-world' health promotion action. Additionally, key stakeholders from industry provide guest lectures in many units, and students participate in site visits to key health promotion agencies, authentic assessment and work-integrated learning to mirror workplace tasks. An outcome of the latest course review was introducing an assessment series to enhance health promotion identity and monitor student achievement of the Competencies and Standards across the course. Across three units, students explore their knowledge and skills within each of the nine competency domains and measure the development of global citizenship through course progression

(continued)

Table 8.2 (continued)

Questions	Take-home messages
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	Curtin's health promotion courses were the first in Australia to map health promotion competencies to the curriculum, and in 2016, the BSc Health Promotion course was the first in Australia to receive accreditation with IUHPE. Our course is carefully mapped against the IUHPE Core Competencies and Professional Standards for Health Promotion, and our units focus on the health promotion principles and ethical values promoted by IUHPE. We also include an Australian and Indigenous focus in the Course, and the Indigenisation of the curriculum has been a vital step in 'closing the gap' between the life expectancy and health outcomes between Indigenous and non-Indigenous Australians. Since 2011, all students enrolled in Curtin University's Faculty of Health Sciences (which includes Health Promotion) complete a specialised Indigenous cultures and health unit in their first year of study. This unit is predominantly managed and co-taught by Aboriginal and Torres Strait Islander staff
What could others learn with your experience? What is localised and what is "generalisable"?	Our chapter presents processes involved in developing and delivering courses to support graduates to respond to and meet current and emerging challenges. Curtin University has a strong history of mapping and embedding health promotion competencies into the curriculum. The continuous curriculum review and re-development over three decades has ensured that courses have remained contemporary and closely aligned with national and international developments in health promotion competencies. The experience at Curtin highlights the importance of close engagement between academic staff and industry stakeholders, students and external academic staff during course reviews to ensure that revised units reflect a contemporary approach to health promotion. The Competencies and Standards provide an essential benchmark for health promotion learning and teaching. Their use ensures that students graduate achieving the expected graduate attributes articulated by IUHPE and equips them to become ethical, knowledgeable and skilled health promotion practitioners

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Part II
Making Health Promotion Relevant to Practice

Chapter 9
Introduction to Part II: Making Health Promotion Relevant to Practice

Dais Gonçalves Rocha

Contents

Since the early 2000s, different efforts have been made to map workforce capacity building (Mittelmark et al., 2005, 2007), opportunities (Arroyo, 2009), and educational approaches (Battel-Kirk et al., 2009; Shilton et al., 2001) in health promotion (HP). Currently, it is a great challenge to train workforce in HP in order to contribute to reduce health inequities and promote sustainable development in the scope of undergraduate, graduate, and other levels of academic training and certification (Akerman et al., 2019; WHO, 2016).

As for educational level, Chap. 20 presents a stricto sensu graduate experience, one for undergraduate and two for permanent education in the services, of which one is aimed at the technical level through collaboration between university and health service.

HP is often part of courses for professionals who have a different dominant professional identity, and the challenge is making it specific and relevant. Verna B. McKenna, Collette Kelly, and Margaret M. Barry, in the Chap. 10, discusses the importance of having HP as an explicit component of a Social Care Program in undergraduate courses. The authors highlight "that delivering the program through a dedicated Subject of Health Promotion offers a unique opportunity to embed health promotion principles into social care practice teaching" in a variety of settings and "to align with all of the Ottawa Charter actions areas."

Also, many professional categories will have a capacity building opportunity in HP when they are already in the world of work. The Chap. 11, by Marguerite Daniel and Helga Bjørnøy Urke, describes a new master's program where an interdisciplinary staff with backgrounds in health promotion, geography, development studies, psychology, and social anthropology admit students with a bachelor's degree in a broad range of social and health sciences related to HP and gender.

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Rolando Bonal Ruiz and Maria Eugenia García Céspedes in "Professional Development in Health Promotion for Family Doctors: Using the Approach of Entrustable Professional Activities" present a competency-based training to improve and update the HP of family doctors in a semi-rural municipality. In this experience, family medicine staff have the opportunity to interact with social actors of the community; local government; community, social and political organizations; presidents of popular councils; district delegates; and social sectors of the community such as representatives of physical culture and recreation, urban agriculture and other local projects. This interaction with representatives of civil society creates spaces for voices from population and potential intersectoral collaboration that incorporates local knowledge and partners with communities.

The Chap. 12, presented by Denise Ribeiro de Deus et al., recognizes, in the Brazilian experience, that the implementation of the "National Policy for Health Promotion (PNPS) and the National Policy of Permanent Education in Health (PNERS) contributed to the recognition of the workplace as a learning space and the need to specific training for health promotion" (Lobato et al., 2016). One of the singularities of this chapter, in Part II, is that it was implemented in the context of the COVID-19 pandemic, in 2020. In addition to the topic, "Take care of yourself to take care of others: Promotion of the Unified Health System Workers' Health and Covid-19," it constitutes an important learning experience to know the different activities conducted in the virtual format and the main challenges for their development in peripheral urban contexts under social vulnerability.

Despite the four chapters investing in interprofessional education (WHO, 2010), with two or more professions from a collaborative practice developing HP plans and actions, it is necessary to point out that both Chaps. 12 and 13 demonstrate that teaching and learning HP experiences result from a university-service-community partnership. This perspective follows the guidelines of the report by the "Lancet Commission on education of health professionals for the 21st century": "the education and health systems share what could be thought of as a joint subsystem—namely, the health professional education subsystem" (Frenk et al., 2010, p. 1928). Unlike other frameworks on the subject of changes in health education, the one proposed by the Lancet Commission "conceives of the population as the base and the driver of these systems."

HP field and the Lancet Commission framework share several core priorities, such as intersectoral approach, social participation, and strengthening community action to reorient health services and their resources. Thus, educational and health institutions must be open and available for mutual support. They must have channels for listening, planning, and evaluating a common work agenda. The big challenge is to share power within the department and with other departments, other subjects, especially in times of austerity without "radical empathy" (Nogueira et al., 2021).

Considering the socio-environment and its relationship with health in rural and urban contexts, the authors of Chaps. 7 and 8 explicit values and principles presented in the 2030 Agenda. They reaffirm the objectives of HP in the Sustainable

Development Goals (SDG), especially SDG 5, related to gender equality, and SDG 10, related to empowerment and reduced inequalities.

All chapters show the importance of teaching and learning in HP in real-life situations, making it relevant to practice. This means that the educational process must take place within community reality and settings and at different levels of social services, with interdisciplinary work. It corroborates one of the roles that the Curitiba Statement gives to health professionals and researchers: "to implement new processes to achieve effective social participation, inclusion, intersectoral action, and interdisciplinary approaches" (Akerman et al., 2019, p.19).

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Chapter 10
The Health Promotion Model of Social Care: Development and Application in Pedagogy for Social Care Practice

Verna B. McKenna, Colette Kelly, and Margaret M. Barry

Contents

Social Care in Ireland

Social care is defined as 'a relationship based approach to the purposeful planning and provision of care, protection, psychosocial support and advocacy in partnership with vulnerable individuals and groups who experience marginalisation, disadvantage or special needs' (Social Care Workers Board, CORU). CORU (Health and Social Care Professionals Council) is Ireland's multi-profession health regulator. Its role is to protect the public through the promotion of high standards of professional conduct, education, training and competence through statutory registration of health and social care professions. It is made up of the Social Care Professions Council and the Registration Boards. The principles of social justice and human rights are central to social care practice.

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Social care workers plan and provide professional care to vulnerable individuals and groups of all ages who experience marginalisation, disadvantage or special needs. The work involves both protection of, and advocating for, individuals and groups and supporting clients towards achieving their full potential. Client groups vary across a wide range of population groups and include:

- Children and adolescents in residential care
- Young people in detention schools
- People with intellectual or physical disabilities
- People who are homeless
- People with alcohol/drug dependency
- Families in the community
- Older people

Interpersonal relationships are central to social care work, and these require empathy, excellent communication skills, self-awareness and an ability to use critical reflection. Teamwork and interdisciplinary work are also important in social care practice.

Social care in Ireland has undergone significant changes in the past decade, as it underwent the process of becoming a registered profession within a statutory framework. These changes also necessitated education providers having to ensure that curricula met the revised regulatory and education and training standards (CORU, 2017). At NUI Galway, the BA in Social Care programme offered by the Discipline of Health Promotion, National University of Ireland Galway (NUIG), has evolved from adult education programmes developed in the late 1990s to a 4-year BA level first offered in 2008. In order to meet the changing requirements, NUIG undertook a review of its existing curriculum for the BA Social Care programme. A key outcome of this was the development of a Health Promotion Model of Social Care to embed the principles and values of health promotion throughout the programme (Battel-Kirk, 2011) (see Fig. 10.1).

The development of this model drew on the Competencies Framework for Health Promotion (Barry et al., 2012). The CompHP Core Competencies Framework (Barry et al., 2012) is underpinned by the Ottawa Charter for Health Promotion (WHO, 1986) for its values, principles and basis for key action areas. This framework was consistent with much of the knowledge, skills and ethical decision-making underpinning the revised standards for social care practice. For more details on this framework, please see Chap. 35, 'Core Competencies for Health Promotion: Development and Experience in Pedagogy' (Battell-Kirk & Sendall, M).

The Health Promotion Model of Social Care

Within the BA Social Care Programme, the Health Promotion Model of Social Care aims to provide excellent care in a way that incorporates a health-promoting approach, for service users, families and social care professionals themselves. The principles of health promotion can be integrated into social care practice in order to

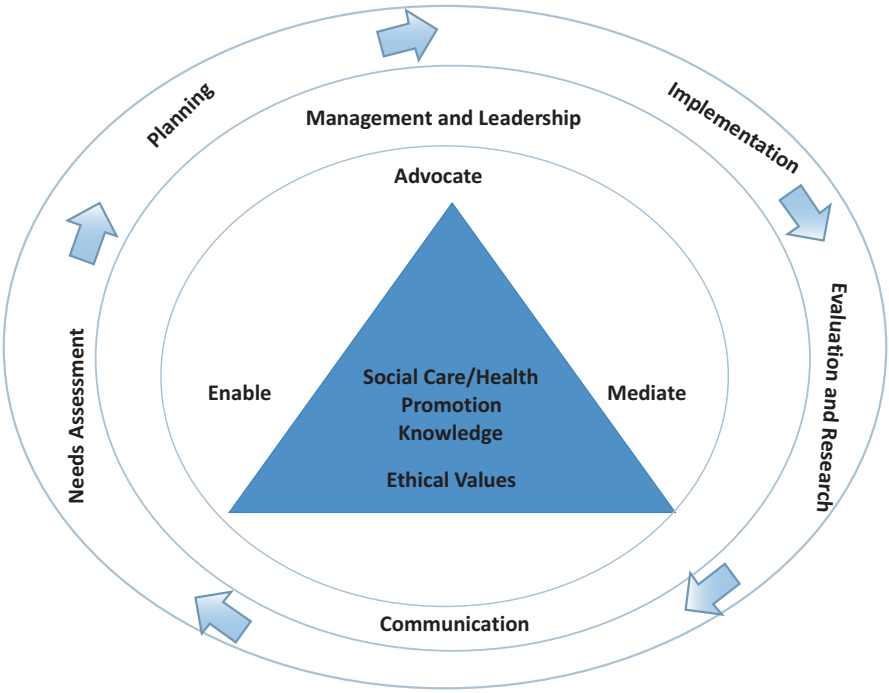

Fig. 10.1 Health promotion model of social care (Adapted from Barry et al., 2012)

inform high-quality social care practice and strengthen social care outcomes. Both health promotion and social care involve values-based actions. The central tenet of health promotion, to enable people to take control of their health, is underpinned by empowerment and participative approaches which are also central to social care practice. Social Care Ireland (SCI), the professional representative body for the social care work profession in the Republic of Ireland, emphasises that practice centres on a perspective based on respect for the dignity of clients; social justice; and empowerment of clients to fulfil their full potential (Social Care Ireland, 2020).

Another key tenet of health promotion, to address health inequalities and the broader determinants of health, is also central to social care practice. The relevance of health promotion to the practice of social care was further affirmed in Ireland's Health Service Executive's (HSE) Strategic Framework, published in 2011, which emphasised the need for the reorganisation of health and social care services to include the development of organisational structures that support the promotion of health (HSE, 2011).The framework is of particular relevance to work in social care as it emphasises the need to develop the skills and capacity of those outside the health promotion workforce to adopt a stronger evidence-based health-promoting role.

This model is centred on the knowledge base and ethical values for both health promotion and social care, and in particular within the domains of enable, mediate and advocate. Additional core areas include accessing needs; planning; implementation and evaluation; management and leadership; and communication. Best practice in

social care can be achieved through use of well-established health promotion approaches set out in the Ottawa Charter (WHO, 1986).

Each of the action areas of the Ottawa Charter can be utilised to underpin empowering social care practice as outlined in Table 10.1.

How the Model Is Delivered in Teaching

The health promotion model is now embedded in modules on health promotion which span all 4 years of the BA Social Care Programme (see Table 10.2).

Teaching and Learning

Pedagogical Approach

Teaching on the BA Social Care Programme is aligned with Kolb's experiential learning theory (Kolb, 1984; Kolb & Kolb, 2005) whereby learning involves the acquisition of abstract concepts that can then be applied in different situations. Students' workshop-based learning of conceptual knowledge is considered in the work experience and practice placement context. Thus, it is aligned with Kolb's four-stage learning cycle which posits that the learner has concrete experiences and engages in reflective observation of the experience and abstract conceptualisation (learning from the experience) and active experimentation (trying out what is learnt). The development and implementation of health promotion interventions for the service users, an element of the practice module, clearly illustrates this.

The fundamental teaching approach employed on the BA Social Care Programme emphasises that each student is viewed as an 'active learner' (Perkins, 1999), and

Table 10.1 Application of Ottawa Charter to social care practice

Ottawa Charter action area	Application to social care practice
Developing personal skills	For service users to enable them to lead healthy, active and meaningful lives
Strengthening community action	This action can be both in relation to the care setting as a community and in relation to 'care in the community'
Healthy public policy	Emphasis on advocating for polices, at macro or micro levels, which impact positively on all aspects of service users' health, development and wellbeing
Creating supportive environments	Supportive environments for service users are those which maximise their potential in all aspects of life – emotional, social and physical. Such environments are also supportive for families, other carers and social care professionals
Reorienting care services	Reorienting care services and service providers towards a more health-promoting and inclusive approach to social care

Table 10.2 Health promotion modules and learning objectives on the BA Social Care Programme

Year	Title	Learning outcomes
1	Health and health promotion in the social care context	1. Describe the definitions and concepts of holistic health in the context of social care 2. Discuss the key definitions of health promotion 3. Identify the shared principles and values underpinning health promotion and social care practice. 4. Define the structures and functions of the human body, and relate this to disease processes and dysfunction 5. Demonstrate understanding of the need to maintain one's own health
2	Health promotion model of social care	1. Relate the health promotion action areas defined in the Ottawa Charter to the social care context 2. Discuss how health promotion principles can inform social care practice 3. Describe examples of empowering and participative practice in the social care context 4. Demonstrate understanding of the role of an advocate, both for and with service users and others 5. Explain the importance of working in partnership with other disciplines, services users and other sectors, and mediating across differing interests
3	Health promotion approaches and strategy in the social care context	1. Differentiate between different health promotion strategies and approaches 2. Relate action areas of the Ottawa Charter to the social care setting 3. Report on examples of effective and ethical advocacy interventions 4. Discuss community development approaches to health promotion with reference to social care practice 5. Analyse social care settings in the context of workplace health promotion
4	Health promotion practice in social care	1. Critically discuss how to plan a health promotion intervention 2. Demonstrate understanding of the key steps in conducting a needs assessment for health promotion 3. Explain the key components of models of behaviour change 4. Report on the key components of brief intervention for use within settings

thus bring their own experiences into the learning process. Teaching also draws on a constructivist approach described by Carlile and Jordan (2005) as a process where individuals 'construct' their own meaning based on previous knowledge and experiences by matching these to new ideas, knowledge and experience. This focus on the 'active learner' is demonstrated through the use of enquiry-based learning which requires students to actively engage in developing material and to engage with values and theories relevant to the specific module topic. This is evident in the teaching of health promotion on the BA Social Programme where students engage with theory and concepts in the context of their own individual and shared practice experiences.

Teaching and Assessment Methods

Teaching is delivered through a blended learning approach. Face-to-face contact is through workshops with students using an enquiry-based approach where students discuss vignettes with their peers across different practice settings. The sharing of student practice experience is a crucial component of student learning on the programme.

As illustrated, there is a clear overlap between the values and principles of health promotion and social care. Despite this, many social care workers do not easily recognise the role of health promotion in their work. Curriculum content on the BA Social Care places a strong emphasis on reflective practice, providing students with the opportunities to reflect on and demonstrate' how they use health promotion approaches in their work, what gaps exist and how to incorporate health promotion approaches. This emphasis on consistent application of theory to practice is a core part of both contact teaching and assessment on the programme. For example, students across all 4 years complete a portfolio based on placement interventions (assessment of need, planning, implementation and evaluation) with an emphasis on linking theory to practice with a particular emphasis on health promotion, including explicit reference to the principles of health promotion. Student feedback on all BA Social Care modules is collated each academic year. For each specific module, students are requested to indicate (using Likert scale) their views on various aspects of the module and its delivery. These include the level of satisfaction with module organisation, clarity of learning outcomes and approach of lecturers (enthusiasm; patience in explaining difficult concepts, alignment of the coursework, assessment of learning activities; enjoyment of module).

Student feedback on the health promotion module is generally positive with students being able to elucidate their practice in terms of their central role in empowering their clients. In addition, students engage well with the year 4 module on health promotion practice in social care where they have the opportunity to explore brief intervention and motivational interviewing techniques as part of their practice.

Assessment of health promotion modules across the BA Social Care Programme includes a range of methods incorporating individual essays, exams, group-based work, presentations, practice portfolio, posters and the final year dissertation. All assessments include the requirement to connect theory to social care practice examples.

Examples of assessments undertaken which draw on the health promotion model of social care include:

- Group-based project work to create posters focussing on a specific strategy of health promotion practice (advocacy/empowerment/mediate through partnership) applied to social care practice
- Individual essays addressing case studies to identify appropriate health promotion interventions focussing on an aspect of the model and its link to practice experiences

- Devising an advocacy plan drawing on WHO's advocacy plan toolkit (WHO, 2006) in response to a case study
- Discussing health literacy and its application to social practice

Practice Placement

The practice placement module, across all 4 years of the BA programme, allows students to observe and practice professional social care work in a variety of settings and to experience the social care work environment. During practice placement, students are expected to demonstrate and achieve the competences required for professional social care practice, thereby linking the academic curriculum to social care work through evidence and knowledge-based best practice. Practice placement aims to introduce students to the culture of the social care profession and to enable them to become socialised into that profession. It facilitates the development and application of the knowledge, attitudes, values and skills needed for the execution of appropriate professional behaviours. It also gives students the opportunity to practice under supervision and to be assessed against professional standards and behaviour, ethical practice and inter-professional partnerships (Discipline of Health Promotion, 2019).

The academic and practice education curriculum across the 4-year BA (Hons) Social Care Programme is designed to ensure students develop and attain the competencies required of a professional social care worker. Application of the Health Promotion Model of Social Care is a key component of learning outcomes for each year within the practice module. In year 1, a key learning outcome is that students are expected to demonstrate understanding of the contribution and value of research and policy in developing evidence-based practice and developing the social care profession using a Health Promotion Model of Social Care. Students are further expected to demonstrate ability to contextualise practice and competence within the Health Promotion Model of Social Care in the second, third and fourth years of the programme. Application of the practice module is assessed as part of the written portfolio that students submit. Previous work carried out at NUI Galway has shown that the use of a portfolio does promote high levels of reflection across the entire course, rather than only within a practice module. Competency-based reflective portfolios are useful tools which draw together theoretical and experiential learning (McKenna et al., 2011).

The inclusion of a health promotion model of social care ensures that students are equipped with a comprehensive and holistic approach to their practice.

An example of this is the inclusion of the topic of health literacy in the curriculum.

Health literacy is a critical factor in empowering people to take charge of their health (WHO, 2013). Improving health literacy is consistent with the principles of health promotion. It promotes individual, family and community health-seeking behaviours, empowers individual citizens to demand rights and quality services and

enables engagement in collective health promotion action (WHO, 2017). Health literacy is understood to be

> *linked to literacy and encompasses people's knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning healthcare, disease prevention and health promotion to maintain or improve quality of life during the life course* Sørensen et al., 2012, pg. 3

This topic aligns with all of the Ottawa Charter action areas, taking into account health literacy need at the individual level through to creation of supportive environments. Raising awareness of this area has allowed students to think about their own health literacy, that of their clients, and how client health literacy needs can be met. Within the social care context, one element is to examine health literacy through the lens of persons with intellectual disabilities which also necessitates a focus on how health service organisations can respond to this challenge. Teaching draws on the work of Chinn (2017), to explore health literacy challenges for people with intellectual disabilities.

Another example is the emphasis on mental health promotion as an important element for both service users and carers within the social care setting. In line with the re-orienting of the health services of the Ottawa Charter, health promotion within social care places emphasis on the recovery-oriented services and promoting social inclusion for people with mental health problems. The recovery-oriented approach, advocated in social care practice, emphasises the social recovery of the client and is based on promotion of empowerment and personal growth. In line with the principle of health promotion, it examines the holistic needs of the client, moving beyond a biomedical focus.

Students use the Health Promotion Model of Social Care to explore social care practice for different population groups and settings. For example, for young people in the residential setting, the issues of obesity, diet and physical activity are of particular relevance. Students in year 4 of the programme explore various models of behaviour change and develop knowledge of brief intervention techniques to assist them in enabling clients to make lifestyle changes. Students may also undertake health promotion interventions to address such issues as part of their placement.

Conclusion

This chapter has described how a health-promoting pedagogy has been embedded into the teaching of social care practice in an Irish University. It has provided an insight into the development and application of a Health Promotion Model of Social Care. Using examples of its application to pedagogy in social care, we have demonstrated how the model can enrich and broaden the scope of social care teaching and practice.

Embedding a health promotion model into teaching, assessment and practice on the BA Social Care Programme has enhanced the teaching and learning experience on the programme. Students can readily identify the health promotion element of

their practice, particularly in the areas of enabling, advocacy and development of personal skills. In time, as graduates move into positions of leadership and management, it is anticipated that health promotion will be increasingly embedded in policies to support best practice for a health promoting approach to service delivery. The experience at NUI Galway can be transferred to teaching and learning for other allied health professional programmes in both Ireland and further afield. In this regard, the authors believe that the approach undertaken on the BA Social Care Programme at NUI Galway can be generalised. However, it should be acknowledged that delivering the programme through a dedicated Discipline of Health Promotion offers a unique opportunity to embed health promotion principles into social care practice teaching.

Table 10.3 brings our reflection on the six triggering questions suggested by the Editors.

Table 10.3 Authors' reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	Our overall vision is to advance the promotion of health and wellbeing through the development of health promotion research, education and training. This embraces the following key objectives: To provide multidisciplinary education and training that is flexible, accessible and relevant To generate and disseminate health promotion research of national and international relevance To translate research that will lead to the development of healthy public policy and evidence-informed practice To provide international leadership in the development of the health promotion theory, research and methods To work in the University and the wider community in ways that reflect the principles and values of health promotion
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	Our health promotion teaching and research activities are underpinned by the core concepts and principles of the Ottawa Charter for health promotion (WHO, 1986) and are guided by the values of equity, empowerment and sustainability and are intersectoral and holistic Our teaching programmes aim to provide a diverse range of students from different disciplinary backgrounds, both full-time and part-time, with a professional education and training in the principles and practice of health promotion. Our taught programmes are based on the core competencies for health promotion as identified in CompHP project and applied in the IUHPE Global Accreditation System The Discipline of Health Promotion delivers innovative teaching and research in health promotion. Established in 1990 with support from the Department of Health, this academic centre is the only one of its kind in Ireland. Our dynamic research programme is carried out through the Health Promotion Research Centre (HPRC), which is designated as a World Health Organization Collaborating Centre for Health Promotion Research

(continued)

Table 10.3 (continued)

Questions	Take-home messages
Which theories and methodologies are used in the teaching-learning process?	Kolb's experiential learning cycle Case studies Reflective practice Enquiry-based learning Student as 'active learner' Constructivist approach
What kind of forms of assessment are applied, results achieved and challenges faced?	Essay Exams Practice portfolio Posters Reflections Dissertation Presentations Peer assessment Group work
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	CompHP Framework Ottawa Charter Principles of Health Promotion
What could others learn with your experience? What is localised and what is 'generalisable'?	The application of the CompHP for a 'Health promotion model of social care' is generalisable for social care programmes in other jurisdictions. It is also applicable to programmes targeting health and allied health professions in order to embed the principles of health promotion into practice

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Chapter 11
Extending Student-Active Learning into Effective Practice in Global Development-Related Health Promotion

Marguerite Daniel and Helga Bjørnøy Urke

Contents

Introduction

The production of competent development-related health promotion practitioners requires teaching and learning that is coherent across theory and practice. Student-active learning is promoted for its excellent outcomes such as deep learning, better understanding, greater ability to solve problems and longer memory of content. However, student-active learning is often applied in theory classes with no extension to or application in related practice. Biggs (1996) coined the concept of 'constructive alignment' in which teaching and learning activities (such as student-active

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learning) are aligned with the desired outcomes of the learning (such as practical application) and the selected form of assessing student learning.

Context

In the Department of Health Promotion and Development at the University of Bergen, Norway, we have long experience of student-active learning, particularly the method of problem-based learning (PBL). In 2002, most of the teaching staff attended a workshop at Maastricht University, Netherlands, to learn the method. It has been used ever since in the department with knowledge and experience being passed on to new generations of teachers.

In 2015 the Faculty asked us to set up a new master's programme, and we used the opportunity to design a programme that attempts to extend student-active learning into practice experience. The new two-year M. Phil programme (120 ECTs in total) that started in autumn 2016 is called Global Development Theory and Practice (GLODE, 2021). We admit a new cohort of between 20 and 30 students every year for one year of taught modules followed by a second year of thesis writing (or students may choose to do an internship plus a short thesis). We accept both Norwegian and international students, and we have between ten and 15 nationalities per cohort, with students coming from Asia, Africa and Latin America as well as North America and the European Union. The programme has two specialisations (Health Promotion and Gender), and we admit students with a bachelor's degree in a broad range of social and health sciences related to these two specialisations. We have an interdisciplinary staff with backgrounds in health promotion, geography, development studies, psychology and social anthropology.

In this chapter we describe two of the five taught modules, firstly a 20-ECT (12-week) introductory module called 'Critical Approaches to Global Development' (for the rest of this chapter, we refer to this as the 'theory module' (GLODE 301, 2021)) and secondly a 10-ECT (7-week) practice module called 'Development Practice' (referred to in this chapter as 'practice module' (GLODE 307, 2021)). Both modules involve approximately six to ten hours of classroom-based teaching and learning activities per week in addition to self-directed learning. Both courses are taught annually. [Three courses related to the Health Promotion specialisation are described in another chapter].

The overall objective of this chapter is to describe the *ongoing process* of designing and improving a course to prepare master's students for development-related (health promotion) practice. Our first sub-objective is to describe the process of trying to achieve constructive alignment *within* two modules: (a) a theory module and (b) a practice module. Our second sub-objective is to describe the process of trying to achieve coherent outcomes *across* two modules (theory and practice).

Theories and Methodologies Used in the Teaching-Learning Process

Constructive Alignment

Coherence between the objectives of a course, the teaching and learning methods and the way the course is assessed, can enhance the teaching and learning experience for all involved. Biggs (2003) contends that meaningful learning is constructed by the student through relevant learning activities while the role of the teacher is to create a context in which such learning can occur. He understands teaching and learning as a system in which all components should be aligned in order to maximise the outcome. The procedure to achieve 'constructive alignment' involves establishing clear learning outcomes that students are expected to achieve; selecting teaching and learning activities that are most likely to result in these intended outcomes; and, finally, designing assessment that positively evaluates how well students have achieved the outcomes (Biggs & Tang, 2015). It is helpful to view the process of constructive alignment as iterative and dynamic so that course design and implementation can evolve (Ruge et al., 2019). Biggs (1996) notes that student activities during lectures tend to be passive and receiving (listening, comprehending, etc.) and these are not activities that will result in outcomes of 'deep learning' such as development of analytic skills and active integration of new concepts with old (Gordon & Debus, 2002; Wang et al., 2013).

Formulating sound learning outcomes is key to the process of constructive alignment. Biggs (2003) distinguishes between *declarative* knowledge (knowledge that can be declared in written or oral texts) and *functioning* knowledge (knowledge that is put to work in practice, that functions). The former is usually content-based, while the latter reflects 'what students should be able to do after being taught and how well they should do it' (Biggs & Tang, 2015, p. 32). In various texts, Biggs refers to the importance of using high-level verbs in formulating learning outcomes: reflect, solve unseen complex problems, generate new alternatives, create, evaluate, improve (practice), etc. (Biggs, 1996, 2003; Biggs & Tang, 2015). Satisfactory functioning knowledge might include 'apply' or 'recognise', but levels of understanding below that tend to be declarative (Biggs, 1996). Biggs' 'functioning' knowledge resonates with Hanstedt's (2018) concept of 'authority' which he contends is more than just content knowledge and skills, but also includes ability to engage in the meaningful questions of the day. Current 'wicked' problems – comprising constantly changing dynamics or parameters, solutions that no longer work and incomplete or contradictory data – need 'wicked students' to solve them (Hanstedt, 2018). Wicked students can reflect, ask the right questions to solve complex problems, adapt ideas or technologies to new or alternative settings and are not afraid to fail and try again (evaluate and improve) (Biggs, 1996; Hanstedt, 2018).

Student-Active Learning

Active engagement in the learning process leads to students learning more than when they are passive recipients of transferred knowledge. Student-active learning is 'any instructional method that engages students in the learning process' and is often contrasted with the passive learning of traditional lectures (Prince, 2004, p. 223). Methods include group work (which may be collaborative or co-operative) and problem-based learning (PBL) (Prince, 2004). PBL uses collaborative teamwork to develop students' self-directed learning practice, critical thinking skills, deep disciplinary knowledge and their ability to reflect on these processes (Reinschmidt et al., 2019; Yew & Goh, 2016). Students develop interpersonal skills; they learn to listen, to give and receive constructive feedback and to evaluate themselves relative to their peers (Servant-Miklos, 2019). Research evaluating the effectiveness of PBL has found that PBL (compared to lectures) makes little difference in short-term acquisition of knowledge, but when it comes to long-term knowledge retention, problem-skill development and satisfaction, PBL outperforms other learning methods (Tawfik & Lilly, 2015; Yew & Goh, 2016). Madsen et al. (2019) contend that collaborative learning and group work throughout a course foster the development of the skill set needed to work in health promotion partnerships between individuals, communities and governments.

Interestingly, research has shown that STEM students who are engaged in active learning may actually believe that they learn *less* than through lectures and that active learning has few benefits (Deslauriers et al., 2019). Initial engagement with a problem they do not know how to solve may frustrate and confuse students, unless tutors and teaching staff explicitly present the benefits in terms of long-term learning, problem-solving skills and critical thinking (Deslauriers et al., 2019). Prince (2004) evaluates different forms of active learning in engineering subjects, and regarding PBL, he notes that negative effects will be perceived when non-expert tutors are used. In addition, he recommends that problem-solving skills be taught explicitly in order to maximise the benefits of PBL.

Linking the above discussion on theory and methods, student-active learning appears to be an effective way of teaching and learning the high-level verbs needed in learning outcomes to achieve Biggs' (2003) *functioning* knowledge. Hanstedt (2018) expresses it thus: 'the best way to create an environment conducive to developing authority in our students, is to place them in situations where they *must assume it*'.

Achieving Constructive Alignment Within Two Modules

In this section our description of the two modules is framed by the dimensions of Biggs' (1996) 'constructive alignment' concept, namely, learning outcomes; teaching and learning activities; and assessment.

The Theory Module

The learning outcomes we aim to achieve in this module include *knowledge outcomes* such as 'advanced comprehension of multi-level and complex processes of development and the role of institutional actors in these processes' (GLODE, 2021), an understanding of contemporary theories in their historical context to encourage critical reflection, ethical framing, governance issues and implications for rights and social justice. *Skills outcomes* include the ability to critically analyse different sources of information (from peer-reviewed articles to organisation reports and websites and media podcasts and videos); to use various perspectives in such analysis (e.g. health promotion or gender); and to understand the implications of the analysis for inequalities and injustice. *General competence outcomes* comprise the ability to communicate coherently, both in writing and verbally, as well as the ability to critically assess, select and apply relevant theories in specific contexts.

We employ a wide range of teaching and learning activities. We start off right away during the introduction/orientation week before the theory module begins. On day two, we give a short lecture about the procedures and beneficial outcomes of problem-based learning (PBL), why we use it and how it works; we get the students to put PBL into practice, working in groups to solve a problem about self-directed learning (see Box 11.1). The groups present their solutions on day three. This activity has a double outcome, as in the process of learning the PBL procedure, the students also discuss self-directed learning with each other – far more effective than a lecture on self-directed learning! Shortly after the start of the theory module, we publish the module's PBL vignettes. We write new vignettes each year that represent development issues or themes within the content of the module (typically climate change, migration/refugees and education), and at the same time, there is a

Box 11.1 Trial PBL Problem

Research shows that learning occurs in greater depth, with more critical reflection and longer-lasting results when driven by the learner rather than the teacher. In other words, active, participatory learning is more effective that 'teacher-tell'. A certain professor wholeheartedly believed and tried to practise this proposition, but year after year, he failed to get his students to read the recommended literature – and as many other participatory activities were based on these readings, they often flopped too. He was sorely discouraged, but before giving up altogether, he tried one more approach.

The professor has commissioned *you*, a group of highly motivated, engaged graduate students, to come up with some strategies (minimum of three) to effectively involve and inspire his students in their own learning.

Table 11.1 Example of PBL vignettes combining themes

Common theme: Food/hunger (SDG 2)		
Group 1: Climate change (SDG 13)	Group 2:Migration/refugees (SDG 10)	Group 3: Education (SDG 4)
A Bergen sustainability group with the goal of mapping knowledge and disseminating it in a locally acceptable way has asked for a review of methods to reduce the demand for meat and other proteins produced in an unsustainable way. They are particularly interested in the potential use of insects or maggots. They have asked you, as students of Global Development, to advise them on: 1. What alternatives exist and where have they been successfully promoted? 2. How they can learn from successful projects elsewhere to promote protein alternatives here in Bergen?	Erik is a volunteer in the Red Cross. He works as a 'guide', usually meeting refugee men for several months to guide them through aspects of Norwegian society. Erik noticed that the men he works with – from Syria, Afghanistan, Iraq and Congo – often mention how difficult they find 'food issues' in Norway: (i) they miss their favourite home-country foods, (ii) they (or more often their wives!) are unsure how to prepare and serve Norwegian foods like cheese and salmon and (iii) they miss the social customs around food – like sharing with male friends in street cafes. Erik discussed these issues with fellow guides and the Red Cross has asked you to come up with some strategies to help refugees deal with food issues	NORAD[a] is a strong supporter of the sustainable development goals. One of NORAD's priority areas is supporting schooling in poor countries and trying to ensure that all children have equal access to schooling. NORAD has been challenged by an NGO in Malawi (one of the countries receiving substantial support from NORAD) to channel more funding to school feeding. NORAD has now commissioned you, as members of a small independent research organisation, to investigate the pros and cons of using funds for school feeding (as opposed to one of the other methods of supporting schooling).

[a]NORAD is the Norwegian Aid Agency

common theme between the groups (in 2020 it was Covid-19; in 2019 it was 'food'; see Table 11.1). We set up the groups to contain maximum diversity in gender, nationality and previous education. Unlike the trial PBL, the module PBL stretches over three or four weeks comprising six tutored two-hour meetings (with additional student-organised meetings and work activities in between) and culminating in a 30-min presentation in which each group member must participate. During the three weeks used to 'solve' the problem, each group member takes a turn at 'chairing' the group and acting as secretary to record decisions made, thus developing leadership skills. The only active role played by the tutor is to lead the *process and progress evaluation* in the last 15 min of each two-hour session. The tutor will also point in the direction of resources if asked by group members.

Communication skills are also central to our teaching and learning activities. During the theory module, we run two three-hour workshops on communication, encompassing both presentation and writing skills. In *presentations skills* we teach about

organising content, timing, engaging the audience as well as feedback: giving feedback constructively, receiving and responding to feedback. (These feedback skills are important during the process evaluation at the end of each tutored PBL session.) Students use presentations, both individual and in groups, as a key means of communication throughout the two years of the programme: in PBL presentations, in student-led lectures, presenting chapters while writing their thesis, etc. Likewise, *writing skills* can be used individually (for writing assignments or for the full thesis in the second year) or in groups (e.g. in report writing).

A range of other teaching and learning activities is also used. *Lectures* are used to present threshold concepts and research-based applications. These also include student participatory activities to promote active learning within the lecture. *Student-led lectures* involve small groups of students preparing a topic to teach the rest of the class. We run workshops to help them structure the lecture and ensure all required aspects are covered. We have found this to be one of the most effective ways to get students to read the curriculum! *Feedback* is given after the student-led lecture. Another group-work approach is the use of *colloquiums*. In their groups, students allocate the set readings between group members, and, guided by the questions for discussion, these are read in preparation before the colloquium. During the colloquium students discuss the questions in-depth in relation to the readings. One group member is chosen as 'rapporteur' to bring the group's conclusions back to the plenary. We also regard the *feedback given on writing assignments* as a teaching and learning tool.

Assessment is not straightforward as we cannot award a single grade based on both group and individual works. To cope with this complexity, we make participation in the group work *obligatory*, and students may only submit their portfolio of two writing assignments once they have fulfilled all obligations. Each student's grade is then based on the portfolio of written work only. Students have a choice within each of the two writing assignments, and they receive feedback on the first assignment with the opportunity to make adjustments before submission. The topics reflect themes the students have addressed in their PBL and student-led lectures (climate change, migration/refugees and education) so that what they write is based not only on their reading around the topic but also on in-depth discussions with other students during the module. Students are able to choose their desired theme in the PBL and student-led lectures – and of course in their writing assignments. A student may choose the same theme across all three activities (in-depth knowledge) or a different theme in all activities (broad rather than deep knowledge). The writing assignment questions address the learning outcome skills and competences as much as knowledge outcomes. The questions provide students with the opportunity to integrate knowledge from their own learning with taught content, to critically analyse and discuss issues from various perspectives and reflect on relationships between the approaches. This form of assessment is in line with Biggs' (1996) *functioning* knowledge.

Results Achieved and Challenges Faced

Student evaluation of the theory module comprises a focus group discussion (without teaching staff present – run by student representatives) on the learning outcomes and the teaching and learning methods, among other things. When students comment on participation in different learning and teaching methods, regarding PBL, they invariably include comments like 'it is a waste of time considering it does not contribute to your final grade'; 'the main concern is how much time, effort and work it requires'. Later in the focus group, we include a question: what contributes most to your learning? Year after year the answer is PBL – and since we have started the student-led lectures, these are included too. In other words, when reflecting on the learning methods separately, students state that they have not learned as much from student-led work as from more traditional teaching methods. This is not surprising, as research shows that student-active learning methods demand more of students and may result in students feeling they learned less than they actually did (Deslauriers et al., 2019). When the question is stated differently, students reflect on the module more holistically and come up with a different answer. Programme staff take evaluations seriously; we discuss most points and respond to core issues raised by the students. We inform the students of our responses through their representatives, and we also make minor adjustments to goals in learning outcomes or our teaching methods. We believe the way we introduce PBL, and the trial PBL problem linking it to self-directed learning, contribute to positive outcomes in the practice of PBL.

Student-active learning methods (PBL and student-led lectures) may require less staff input during the module, but they require thorough planning and preparation beforehand. Framing the module in constructive alignment dimensions has been helpful in broadening our focus beyond only knowledge outcomes. Student-active teaching and learning methods are also effective for teaching and learning skills and general competences.

The Practice Module

The overall aim of the practice module is 'to introduce students to the Development Practice arena first and foremost as a field of practice, but also as a research subject and as the object of critical scholarship' (GLODE 307, 2021). Students work in small groups throughout the module to solve real-life problems identified by public or private sector organisations or NGOs (see some examples in Box 11.3). They write a professional report on the process and outcome. In addition, each group gives an oral presentation of the outcome of their group work to the relevant organisation and the rest of the class.

As with the theory module, the learning outcomes we aim to achieve in the practice module include knowledge, skills and general competence. The main

knowledge outcome in this module is to understand development practice as the facilitation of collaboration across sectors, with the possibility of multiple perspectives, such as human rights, gender, health promotion and integral ecology. Cultural context and practices have significant implications for development practice. In the practice module, there is much greater emphasis on *skills* and *general competence outcomes* (see Box 11.2) with many more specific skills and competences identified than in the theory module.

Teaching and learning methods in the practice module are less varied than in the theory module in that contact time usually involves a workshop to 'teach' relevant concepts or practices, such as the use of log-frames, or how to plan and conduct a needs assessment or an outcome evaluation. Groups then literally work with the concept or practice in the ongoing process of solving the problem they have been set. Assessment is in the form of a portfolio that includes the report to the

Box 11.2 Practice Module Learning Outcomes (in Part)

Skills:

The student has the ability to:
- Conduct community needs and assets mapping
- Negotiate: align, optimise and orchestrate diverging perspectives on community needs, priorities and resources (citizens', local officials', regional, national and global authorities')
- Communicate to colleagues and to community groups and representatives about methods and approaches to development practice
- Facilitate communities in developing, implementing and evaluating development strategies
- Facilitate community-based participatory action research
- Locate particular development projects within local, national and global frameworks

General competence:

The student has the ability to:
- Assist in establishing community collaboration
- Respond to community priorities with suggestions for adaptive action
- Advise communities on actors and resources that are potentially available for community development
- Help build, manage and evaluate community partnerships
- Work effectively across organisational cultures

Box 11.3 Examples of 'Real-Life' Problems to Solve 2017

Establishing a 'people's fridge' in the community to reduce food waste (*Framtiden i våre hender* – 'The future in our hands' an Environmental organisation)

2018 *KombiClass*: an evaluation. Young adult refugees (18+) completing primary school (responsibility of the municipality) in an upper secondary school venue (responsibility of the county)

2019 Loneliness – mapping its extent among students and strategies to reduce it (Red Cross)

organisation, plus the presentation of the group's solution to an audience comprising the organisation, the teaching staff and the rest of the class. We regard this as highly 'authentic' assessment as it is closely related to experiences of working life. Students can list their report on their CVs.

Results Achieved and Challenges Faced

Student evaluations show that they really appreciate the authentic nature of the group work, for example, from the 2019 evaluation: 'Students felt as though the work mirrored real life situations'. They commented that even when organisations failed to give clear instructions, or when there are cross-cultural tensions within the group dynamic, having to deal with these 'mirrors real life situations'. Every year students appreciate having to plan and conduct research as an application of the research methods modules they have completed. Each year we send an email to the participating organisations to ask for feedback, but not one has answered. We do ask for verbal feedback immediately after the presentations, and the organisations are generally delighted both with the report and the presentation.

In 2020, the practice module started in tandem with the first lockdown in response to the Covid-19 pandemic. This was incredibly challenging for a *practice* module! We had to abandon all the planned collaboration with organisations and convert the 'problems' to real-life research problems related to the pandemic (to identify and map creative responses to the lockdown among students, staff and those planning internships). We converted one of the early workshops into how to conduct research ethically using digital means – with an invited expert to instruct us. In an attempt to maintain authenticity, we invited relevant key personnel, such as the Vice-rector for Education, to the final (Zoom) presentations. In their evaluation, the 2020 cohort

stated that they felt unprepared for practice as they had not had the relevant experience with genuine organisations. They know the theory but have not applied it in practice.

Coherent Outcomes Across Two Modules

Achieving constructive alignment *within* the two modules described in this chapter is a work in progress. We actively use student evaluations and our own evaluations on how the module has gone each year to reflect on how we could improve it. In this way, each module is gradually evolving, being updated and, we hope, improving.

Meaningful coherence across the theory and practice modules could enhance overall learning outcomes for students. The most obvious logical progression between the theory and practice modules occurs in our teaching and learning methods. In the theory module, students learn through student-centred and student-active learning methods such as PBL and student-led lectures. In the practice module, students learn through real-life problem-solving working in collaboration with organisations in the public, private or civil society sector (NGOs). The problem-solving procedures and reflective processes learned while solving (fictional) problems in PBL during the theory course are employed with confidence in the authentic task set by the collaborating organisation. The skills and competences of working in teams, exercising leadership and utilising different means of communication are easily transferred from solving fictional problems to unravelling real-life challenges. Likewise, the coherence between forms of assessment is visible between the two modules. In the practice module, the report written by the group builds on writing skills developed in the theory module in the individual writing assignment. Both individual and group presentations in the theory module provide a foundation for the professional presentation the group gives to the collaborating organisation in the practice module.

Coherence between the learning outcomes of the two modules may not, at first, be so obvious. However, if one moves beyond declarative knowledge (the *knowledge content* in each module) to the functional knowledge outcomes (skills and competences), there is a link between the two modules. The ability to deal critically with various sources of information and to analyse challenging issues from various perspectives (theory module) builds the foundation needed to negotiate and align diverging perspectives on community needs, priorities and resources (practice module). The ability to analyse implications of alternative development processes on poverty and vulnerability, inequalities and injustice (theory module) lays the groundwork for communication to colleagues and community groups about various methods and approaches to development practice (practice module).

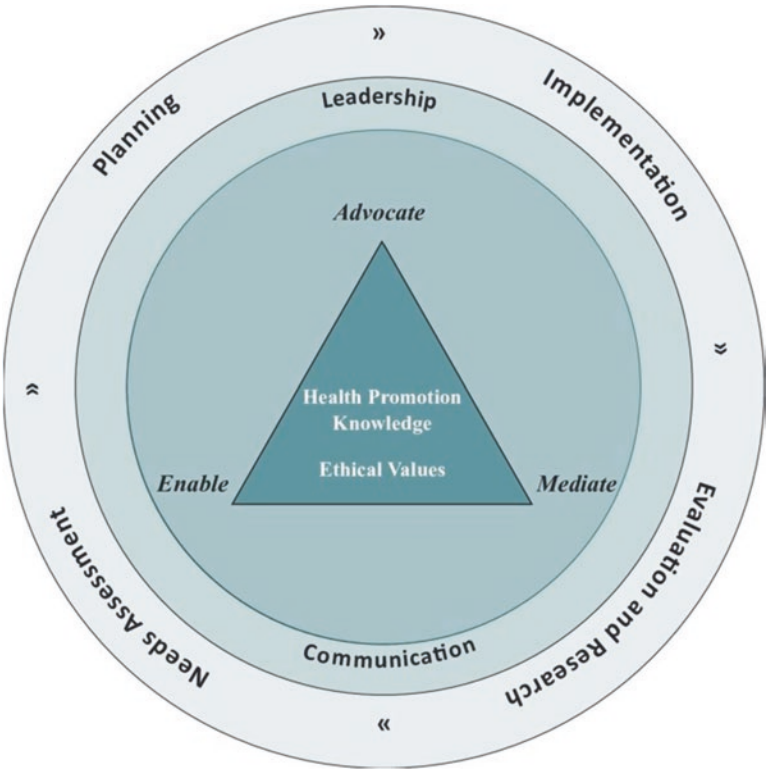

Fig. 11.1 The CompHP core competencies framework for health promotion. (Barry et al. (2012, p. 19))

Discussion

In this section we consider the core competencies for health promotion (Barry et al., 2012) and how well the two modules described above contribute to students developing these competencies. In addition, we consider the potential applicability of our teaching experiences in other contexts.

Core Competencies for HP

The CompHP Core Competencies Framework for Health Promotion (Barry et al., 2012), before describing nine groups of competencies, outlines, firstly, the ethical values and, secondly, the knowledge base underpinning the health promotion core

competencies (see Fig. 11.1). Ethical values 'include a belief in equity and social justice, respect for the autonomy and choice of both individuals and groups, and collaborative and consultative ways of working' (Barry et al., 2012, p. 20). Ethics is explicitly included in the learning objectives of the theory module, and equity and social justice are present in the learning objectives of both the theory and practice modules. Although the knowledge base underpinning the health promotion core competencies is not explicit in the two modules discussed here, we teach it in its entirety in the Health Promotion specialisation module (see also the Chap. 16 by Urke and Daniel in this volume).

The Core Competencies in Health Promotion

The first two competencies are 'enable change' and 'advocate for health'. Barry et al. (2012, p. 22) describe these competencies as including processes such as working collaboratively; using approaches which support empowerment, participation, partnership and equity; using community development approaches to strengthen community participation and ownership; and generally regarding individuals, communities and organisations as stakeholders to collaborate with. Many of the same phrases are found in the learning outcomes for the practice module (see Box 11.2).

Our team-building, student-active teaching and learning methods like PBL and student-led lectures (in both the theory and practice modules) equip our students with several of the competencies. The third competency is 'mediate through partnership' and is described as working collaboratively across disciplines, sectors and partners (Barry et al., 2012). Likewise, our teaching and learning methods equip our students with excellent competence in communication – the fourth competency in the framework. Our students are able to communicate individually and in groups, in writing (of various forms) and in verbal presentations, giving feedback as well as listening and including. In addition, we require our students to rotate leadership during PBL and other group work so that they all have the opportunity to practise it – and during the evaluation – reflect on their own and others' leadership qualities and practices.

The practice module provides students with opportunities for assessment (competency 6), planning (competency 7) and research and evaluation (competency 9). These are all practices and methods that are taught – and then applied to particular real-life problems – during the workshops in the practice module.

Perhaps the only competency which we do not cover in these two modules is number eight, implementation. Students who choose an internship and work with organisations, for example, humanitarian organisations or consultancy firms, may have the opportunity to participate in implementation (see also the Chap. 16 by Urke and Daniel in this volume).

Have We Prepared the Students for Development-Related (Health Promotion) Practice?

So although for both these modules, the Gender specialisations students are included, in fact all the students are learning health promotion competencies that are in development contexts related to their specialisation. For those following the Health Promotion specialisation, they learn the knowledge base underpinning the competencies during the health promotion course (see also the Chap. 16 by Urke and Daniel in this volume), and consequently, by the end of the two years, they are well-equipped for health promotion practice.

The fact that our students include some who are specialising in gender – and they are all present for the theory and practice modules – means that the type of learning and teaching methods we use could successfully be applied in other subjects and disciplines. As shown above, we write our own PBL vignettes, so if courses were taught in very different contexts, it would be a matter of writing vignettes appropriate to that setting in order for students to get a similar learning experience.

Conclusion

The overall objective of this chapter was to describe how we prepare master's students for development-related (health promotion) practice – and the fact that we are constantly evolving and improving the course. We have described two modules in detail, a theory module and a practice module, and shown how we achieve constructive alignment between the learning outcomes (to achieve *functioning* knowledge); the teaching and learning methods (student-active for effective learning); and the forms of assessment (authentic). We have reviewed the links between the two modules and determined that there are coherent outcomes across the modules (theory and practice). We have shown that our students learn eight out of the nine core competencies for health promotion through these two modules. The examples we use in the theory module are related to the Bergen and Norwegian context, and, in the practice module, we work with local available organisations. However, the *processes* we use are universally applicable: highly relevant problems can be generated for a wide variety of disciplines and contexts. Likewise, in practice, collaboration can be arranged with organisations that are available to achieve authentic outcomes.

Table 11.2 brings our reflection on the six triggering questions suggested by the editors.

Table 11.2 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Vision: health promotion should be applicable in all regions of the world – context will shape its form and processes
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	This is a master's level course, and participants include those with a broad range of social science backgrounds or with work experience in health and care services, civil society and public sector. Participants come from 10–15 different countries from the Global North and Global South (out of a total of between 20 and 30 students per cohort) We describe two courses here: a 20-ECT (12-week) introduction course including theory and a 10-ECT (7-week) practice course both courses involve approximately 6–10 h of classroom-based teaching and learning activities per week in addition to self-directed learning. Both courses are taught annually
Which theories and methodologies are used in the teaching-learning process?	Constructive alignment Participation leads to higher quality of learning
What kinds of forms of assessment are applied, results achieved and challenges faced?	We try to align teaching and learning activities and forms of assessment. Participatory methods such as problem-based learning (PBL) is assessed through the final presentation; student-led lectures are assessed through staff and student feedback to the groups presenting the lectures. Knowledge of theories and concepts is assessed through a portfolio of written work submitted at the end of the course. In the practice course, students work in small groups with an organisation to solve a genuine problem. Assessment is *authentic* and comprises a formal written report and a professional presentation of their findings Results: student-active learning leads to a high level of student participation, good presentation and verbal feedback skills, good motivation and generally high levels of comprehension and application Challenges: students often feel that PBL wastes time and they may want more guidance, but in evaluations at the end of the course, they usually rate this as the activity that contributes most to their learning. Resource demanding. Cross-cultural and diverse student groups make it difficult to manage group dynamics
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	In these two courses together, all nine core competencies are thoroughly covered, as are the ethics of health promotion. Many aspects from the knowledge base underpinning the core competencies are used
What others could learn with your experience? What is localised and what is 'generalizable'?	Our student-active learning methods could be applied anywhere, but the specific PBL problems might have been tailored to regional issues

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Chapter 12
TEIA: Intersectoral Topics and Strategies with Community Health Workers (CHWs), Education, Communication, and Health Promotion in Times of Pandemic

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The Crisis We Are Experiencing: The TEIA Project in the Face of a Humanitarian Crisis

On March 11, 2020, the World Health Organization (WHO) classified the disease spread by coronavirus 2019 (COVID-19) as a pandemic. This means that the virus is in circulation on all continents with the incidence of oligosymptomatic cases, making diagnosis difficult. Thus, due to human infection caused by the new coronavirus (2019-nCoV), the Ministry of Health of Brazil declared Public Health Emergency of National Concern (PHENC) through Ordinance No. 188, dated February 3, 2020 (Brasil, 2020). In a context in which health systems are being readjusted and reorganized, in order to mitigate the transmissibility of the new coronavirus, both public health assistance and management are challenged in unprecedented ways to maintain care, surveillance, and guidance for people and their territories. Robbins et al. (2020) point out that health systems need to adapt quickly, seeking to monitor the advance and evolution of the disease leading to the incorporation of innovation in digital health, making use of digital communication, digital educational initiatives, and digital solutions for patient management.

The global pandemic which emerged from the spread of the new coronavirus (Sars-Cov-2) has uncovered a number of burning issues concerning current sociopolitical and economic standards. These issues have been further sedimented by the precariousness of human relations, man's relationship with nature, and strained relationships in the workplace (Souza Santos, 2020; Butler, 2020). Strictly speaking, the pandemic has exposed the fact that the biomedical and hospital-centered health model is inadequate in combating this reality and reinforces the need for social intervention. Therefore, the field of health promotion has become not only necessary but fundamental, supported by the concept of collective health. Firstly, it is necessary to promote the qualification and training of health workers, especially at the primary level. The second measures are the expansion of access to health services and the reduction of institutional and social barriers. The third is the strengthening of the universal Brazilian health model, through the improvements in the Brazilian Health System (SUS), and democratization of its management model (Brasil, 1988).

Nogueira, Rocha, and Akerman (2020) affirm that the implementation of public policies is a way of not returning to the pre-pandemic "normality" and that those policies are based on intersectoral approach, sustainability, empowerment, equity, and the life cycle expectation in the light of health promotion. In this pandemic context, the TEIA project (Intersectoral Topics and Strategies with CHW) was created with the aim of promoting informative activities and health education actions in the form of live streams. These events were transmitted via social media, using the institutional page of the Brazilian health department. The project, focused on health promotion in primary care, was structured with the intention of reporting the potentials and the gaps in training and in the communication agenda. Its focus lies in health promotion in primary care, and its components will be described in this chapter.

The primary objective is to expand work processes and management systems and revise the qualification of primary healthcare through active participation of community workers. The approach is interdisciplinary and multi-professional and focuses on the development of health promotion actions (health education, community participation, public interest, integrative practices, and physical activities).

In detail, the specific objectives are as follows:

- To improve perception, comprehension, and practices for health promotion (HP) after educational interventions and body practices (integrative health practices and integrative physical activities) with the CHWs in an interdisciplinary and multi-professional way
- To encourage specific workers to develop, co-manage, and share the planning of health promotion actions for primary care
- To strengthen teaching-service integration through workshops, short courses, and health training activities for SUS professionals in the São Patrício II Region in the state of Goiás, Brazil
- To create educational support material with and for the CHWs, focused on planning and management in primary healthcare

The expected results from the execution of TEIA involve closer contact between teachers and students of FEFD/UFG[1] in training and management activities with community health workers, primary healthcare managers, and professionals who work in the São Patrício II Health Region (municipalities: Barro Alto, Goianésia, Itaguaru, Jaraguá, Mimoso, Padre Bernardo, Santa Rita do Novo Destino, and Vila Propício); the integration of teaching and the extension program with the participation of students from the disciplines "Management and Policies of Physical Education and Health in Brazil" and "Body Practices and Health Promotion" in the project activities (workshops and short courses); and the expansion of health promotion actions in the territories where the CHWs operate, related to the course of life, human aging, and sociocultural diversity, in accordance with the strategic pillars of the National Health Promotion Policy (NHPP).

A Health Promotion Agenda with CHWs in the Context of a Pandemic

TEIA project aims to integrate and improve the performance of the community health workers (CHWs) as protagonists in healthcare and to develop strategies for health promotion (HP). The project also considers the social determinants, focused on a cooperative, shared, and integrated management model, aiming to achieve improvements in the community's quality of life.

[1] College of Physical Education and Dance of the Federal University of Goiás

In addition, the project seeks to encourage a broader comprehension of the National Health Promotion Policy (NHPP) created in Brazil in 2006 at the level of primary healthcare (PHC), focusing on its strategic pillars. It consequently entails the application of actions and practices in the daily life and work of primary healthcare professionals, considering their comprehension and physical experiences, as well as health experiences. This program is designed in a coherent, intra- and intersectoral manner, with the capacity to promote health at both the individual and collective levels, considering social determinants, vulnerabilities, and the needs of local communities and precincts.

Brazil's Unified Health System (SUS) is organized and coordinated by the primary care level of the health services network (Brasil, 2010b). This system is in dire need of improvements to its interdisciplinary and multi-professional work, as well as the inclusion of community health workers in the care and assistance processes. The expected outcome of this project is the integration of various fields of knowledge with the collective health sector. By using the formative approach, it aims at the reorganization of work processes conducted by the state, municipal, and university management in a chosen region, which spans eight municipalities in the state of Goiás. Last but not least, it hopes to promote CHWs' autonomous involvement in the planning and execution of supervision and of comprehensive actions such as healthy eating, promotion of body practices, mental healthcare, culture of peace, and human rights, in harmony with other SUS professionals (Brasil, 2008, 2009).

The focus on the community health workers (CHWs) arises from the recognition of their relevance and strategic position in the SUS organization. The CHWs have a unique ability to communicate with families and to motivate them to promote health (Brasil, 2010a). This skill makes the CHWs be seen by the community as role models and helps to consolidate the bond of trust between the families and the professional. As such, the CHWs serve as the protagonists in the practice of health education (Silva et al., 2019).

The creativity of community health workers in mobilizing families in promotion of health is not simply a mechanical fulfillment of their tasks but the manifestation of serious commitment to such challenging work. It is also true to say that their work is facilitated by the interdependence of the agent and the families they accompany, with whom they share the same culture and hardships (Brasil, 2010a).

The Community Health Workers Program (CHWP) was created in 1991. Twenty years later, in 2011, the program became part of the National Primary Care Policy (NPCP), and was upheld in the revised version in 2017, by Ordinance No. 2.436 of September 21 (Brasil, 2017). The National Primary Care Policy (NPCP) is considered fundamental for the CHW's performance in a coherent and integrated way in Health Supervision and Health Inspection. Each professional is responsible for activities related to protection, prevention, and health promotion, such as:

- Conducting home visits and active search
- Promoting health to improve quality of life
- Identification of situations of vulnerability which affect health and the health-illness-disease process
- Community guidance on preventative measures against diseases and illnesses

- Encouragement of community involvement and social participation
- Participation in the process of planning, implementing, and managing policies, programs, and projects, in order to enhance intersectoral actions together with the Family Health Strategy team, Family Health Support Centers, primary healthcare managers, and Municipal Health Councils, among others (Brasil, 2017)

It is important to acknowledge the educational role of community health workers, who act as a bridge between the health authorities and the community (Brasil, 2009). It is a work built on trust, belonging, and reciprocity. These elements are all fundamental for the creation of bonds and collective empowerment (Lefevre & Lefevre, 2009).

The abovementioned educational process is co-constructed by the CHWs and the community and is based on the thoughts of Paulo Freire, who valued popular and intergenerational knowledge by recognizing the cultural plurality and the reality of each precinct (Brasil, 2014b), often marked by intense social vulnerability (Broch et al., 2020). Health education – the act of educating in the SUS context – is a critical, creative, and participatory action. Education is a process of transformation, focused on the individual's freedom and autonomy, through corporal experiences, and on the reinforcement of community initiatives (Freire, 1989 e 1996).

Health Promotion in Brazil: Possibilities in Primary Healthcare

The WHO understands health from a positive perspective, conceptualizing it as a state of complete physical, mental, and social well-being and not merely the absence of disease or sickness. In addition, the WHO recognizes that health is one of the fundamental rights of every human being.

Health is considered a social right and is, therefore, one of the several social rights which guarantee citizenship and human dignity. T.H. Marshall (1963, p. 76) states that citizenship, "is a status bestowed on those who are full members of a community. Those who possess this status are equal with respect to the rights and duties that come with it […]." Thus, in order to assure full citizenship, it is essential to guarantee three elements that constitute it: civil law, political law, and social law.

At the end of the 1980s, during the eighth National Health Conference, a reform movement established the guiding principles and guidelines of the SUS. In 1988, the Brazilian constitution confirmed health as a right of every Brazilian citizen and the duty of the state (Brasil, 1988). Therefore, it legitimized the creation of a universal, comprehensive, and decentralized health system.

The Organic Health Law (Law 8.080/1990) thus defines the following guiding principles of SUS:

- The universal access to health services at all levels of assistance
- Comprehensive assistance

- The preservation of people's autonomy in the defense of their physical and moral integrality
- Universal healthcare
- Access to information
- The publication of information
- Social participation
- Political-administrative decentralization and regionalization
- The integration of health actions at the executive level
- Resource pooling
- The organization of public services (Brasil, 1990)

The process of political and administrative decentralization of the public health system itself became a challenge to the implementation of public health policies, mainly to primary care policies (such as the Family Health Strategy; Family Health Support Center; Community Health Workers Program; More Doctors Program; National Program for Improvement of Access and Quality of Primary Care; Health Academy Program; Health at School; Telehealth, among others), which were considered non-hegemonic and in opposition to the biomedical and marketing logic of health services.

The NPCP highlights that primary care is "[…] a body of health actions, at the individual and collective level, which covers the promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation, injury reduction and health maintenance […]" (Brasil, 2012 p. 19).

The National Health Promotion Policy (NHPP) regarding the Brazilian health scenario was created in 2006 and revised in 2014. It highlighted the guidelines and principles of the Ottawa Charter for Health Promotion (1986) and presented hypotheses about the SUS. In brief, the National Health Promotion Policy needs:

> […] to establish a relationship with other public policies achieved by Brazilian citizens, including those in the health sector, such as The National Primary Care Policy (Pnab), the National Food and Nutrition Policy (Pnan), the National Policy for Popular Education in Health (Pnep-SUS), the National Humanization Policy (HumanizaSUS), the National Strategic and Participatory Management Policy (ParticipaSUS), the National Policy for Integrative and Complementary Practices (PNPIC), the National Policy for National Reduction of Morbidity and Mortality from Accidents and Violence, the National Emergency Care Policy, and the National Policies for Comprehensive Health of Minority groups, such as those of the black population and the LGBT population. (Brasil, 2014a p. 08)

It is important to mention that the National Health Promotion Policy, aligned with the SUS law, values the principle of social participation and community involvement and encourages the process of co-management, shared planning, and also the co-responsibility of different social agents. It should be noted that the National Health Promotion Policy is guided by the emerging health paradigm, one of social health production, which differs from the traditional health paradigm with regard to the legitimacy and hegemony of medical authority. At the same time, it provides the general public (including the CHW) with the guarantee to participate in the management of health policies and actions. Furthermore, it envisions both individual

and collective control over people's bodies, health, and lives through the social empowerment process (Brasil, 2008).

The educational and training perspectives have changed over time, from receptive education to critical pedagogy. This paradigm shift in the field of education has influenced the field of health education and, more recently, the context of health promotion (WHO, 2016; OPAS, 2018).

Active Methodologies for Knowledge Mediation: A Dialogistic and Emancipatory Perspective

In November 2020, a consultation began with the community health workers in eight municipalities of a Regional Health Administrative Unit (RHAU), in the Brazilian state of Goiás. An electronic survey was prepared to collect information about the needs and demands in health promotion, and virtual conversations called PROSAs[2] were held via the Zoom platform.

Using Paulo Freire's pedagogical vision as a reference, the TEIA project is based on the dialogical methodology of questioning, i.e., on the liberating perspective and the systemic theory, developing dialogical processes and rotational leadership strategies (Bojer et al., 2010). Each stage of the project follows the logic of collective rationale and collaboration, involving community agents, municipal managers and technicians in the areas of health promotion and primary care at the state level, as

Table 12.1 Methods and strategies – TEIA

Dialogical processes	Co-management/collaborative management
Clarity of purpose and intention Elaboration of questions (shared agenda in the form of questions and World Café[a] method) Valorization of collective intelligence (conversations, meetings, action plans) Shared vision (round-table discussions, shared consolidated report, choice of project name and activities) Rotational leadership (conducting meetings, workshops, and short courses)	Cyclic organization (round-table discussions throughout the process) Organization in group format (conducting group, guiding group, rotating group) Social belonging (everyone included in activities such as PROSAs on Unconventional Food Plants (PANCs), body practices, integrative health practices, individual support, creation of bonds, and active/empathic listening)

[a]Group conversation methodology used worldwide. Created by Juanita Brown and David Isaacs in 1995 in California/USA, this technique is very useful to stimulate creativity, explore topics relevant to the group, and create space for the manifestation of collective intelligence

[2] In a literal translation from Brazilian Portuguese, *prosa* means "prose," but it can also mean "chat"/ "conversation."

well as researchers and students (undergraduate and master's). The stages of the project are organized as follows:

1. Coordination of the Regional Health Administrative Unit (RHAU), the State Health Department (SHD), and the Municipal Health Departments (MHDs): planning and organizing actions remotely, using information and communication technologies
2. Collaborative planning and dialogue facilitation (see Table 12.1): planning through the elaboration of spreadsheets, shared guidelines, and agendas (see Figs. 12.1 and 12.2); selection of tools, topics, and head questions; promotion of the feeling of acceptance and belonging; warm-ups; simulations; collective knowledge appreciation; co-management in groups; CHW rotating leader; and creation of working groups, among others
3. Training and qualification of work processes:
    - Electronic form (Google forms): Survey of demands and priority topics with CHWs
    - Round-table discussions with CHWs: Outline of the possibilities and potential of the performance of CHWs in primary healthcare
    - Workshops for the planning of actions and activities aimed at improving care and assistance in the territories: World Café

Thus, the stages of execution of the project have the following methodologies: World Cafe; liberating structures; plain language; mental maps; conversation groups, and shared consolidated report in spreadsheet and booklet form. It counts on the participation of guides from each of the technical areas of the human life cycle (health of children, adolescents, women, men, and the elderly). And, as stated above, it is based on collaborative and participatory methodologies that relate to Freire's vision.

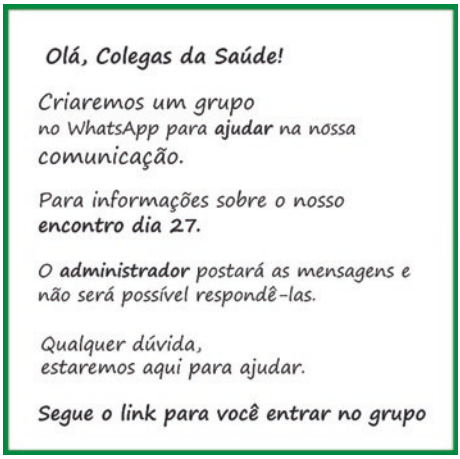

Fig. 12.1 Collective invitation of meetings and information about creation of conversation group in the applicative

Fig. 12.2 Collective agreements and virtual etiquette to be adopted in the remote meetings through the web conference platform

During the project, short courses have been offered to improve the understanding of the methodologies adopted in order to promote autonomy and refinement of CHW's work processes.

The researcher Heloisa Fischer defines simple language as a social cause, a civil right, and a communication technique, which was generated during a movement started 40 years ago in English societies under the name of "plain language." According to the Plain Language Association International (PLAIN), communication is in plain language when the text, structure, and design are so clear that the target audience can easily find what they are looking for, understand what they have found, and use that information. There will be four editions of minicourses aimed at training CHWs in the use of active methodologies and the art of being a host. CHWs will be able to reorganize work processes, both in terms of planning and collaborative management among PHC staff, as well as to mediate assistance and activities with their community/precinct.

From this perspective, the TEIA project uses the resources of plain language to facilitate communication and connections among those involved. Forms, consolidated reports, invitations, meetings, and graphic materials are planned and executed in plain language, according to guidelines such as accessible information, focus on

Fig. 12.3 The post is presenting the collective call for remote meeting: schedule, meeting ID, and password

the main idea; elimination of unnecessary information; clear structure; and choice of images; among other guidelines that aim to facilitate understanding (see Figs. 12.1, 12.2, and 12.3).

Plain language is an approach of inclusion through empathic communication, that is, a carefully constructed writing or communication structure considering the receiver of the message.

Additionally, taking self-care, body awareness, and autonomy into consideration, there will be a subproject aligned with the National Integrative Practices Policy (NIPP) entitled *Cuca Legal*[3]*: Mental Health Promotion for SUS Workers* developing activities designed to work on corporal health practices.

The stages and schedule of the project are presented in Table 12.2.

The evaluation and monitoring of the project are continuous and procedural. During virtual meetings, a self-perception activity is carried out by each participant regarding their progress and engagement in the proposed activity. In the World Café methodology, a systematic report is written collating the conclusions reached in each edition, which is consolidated in a booklet called "Thematic Series with CHWs." Until April 2021, two booklets were prepared: one entitled "Healthy Eating: In Daily Life and in Times of Pandemic," and another called "Promotion of Health Workers' Mental Health in Times of the Pandemic."

TEIA is a pilot project taking place between November 2020 and November 2021, that is, over the period of 12 months. The project was born from a survey of the demands and needs of Community Health Agents, and it was structured into two axes: (1) the Unified Health System Workers' Health and (2) Comprehensive Care and Health Promotion, taking into consideration the stages of the human life cycle

[3] "Cool Mind"

Table 12.2 Schedule – TEIA

Period	Stage
December 2020 to February 2021	Stage one: Preparation and execution of forms to survey demands and possible partnerships Distribution of results to all CHWs, local managers, and superintendents Conduction of 4 virtual conversation groups, with 40 CHWs who wish to participate in the elaboration of the project Disclosure of the consolidated report Upload of video using images from PROSAs
March 2021	Stage two: Planning and execution of the first health action: promotion of workers' mental health in times of the pandemic Minicourse: World Café Preparation of a booklet during the minicourse with the title: *Healthy Eating in Times of the Pandemic* World Café: Promotion of workers' mental health in times of the pandemic
April 2021	Stage three: *Cuca Legal*: Self-massage; medicinal plants, mindfulness, and thermalism World Café: Compassion fatigue in times of the pandemic World Café: Clinical case – limits of community health workers' work Interactive lecture: Orders of help
May to October 2021	Stage four: Planning of health promotion actions and activities related to life cycles *Cuca Legal*: PIS[a], integrative body practices and life cycles
November 2021	Stage five: Planning of health promotion and appreciation activities aimed at specific groups (LGBTQI, black people; rural laborers; ethnic groups; individuals deprived of liberty; indigenous people; migrants and refugees) Seminar on Health Promotion and Life Cycles: Conclusion of the project in the São Patrício II Health Region

[a]Integrative health practices

(childhood, adolescence, adulthood, and old age) as well as the gender perspective (women and men).

Regarding the health of SUS workers, a specific topic was dedicated to it: "Take care of yourself to take care of others: Promotion of the Unified Health System Workers' Health and Covid-19." Within this topic, advances and results focused on the improvement of comprehensive care, the recognition of current issues, and the reformulation of work processes with the community assisted by the community health workers. The results were detailed, revealing a process of rupture with a conservative logic of maintaining routines and conditions. For this purpose, between May and October, 29 activities were carried out (virtual meetings, meetings with CHW conducting groups, short courses, and remote and in-person workshops) addressing sensitive topics suggested by the community agents in the activity planning and meetings organization, in addition to subjects related to each stage of the life cycle and from the gender and diversity perspective (see Table 12.3).

Table 12.3 TEIA projects' activities: mental health; life cycle stages, gender, and diversity

Topic	Activity Name
Mental health	Round-table discussions about anxiety in times of the pandemic Minicourse: When helping hurts, help step by step World Café: Promotion of SUS workers' mental health in times of a pandemic Dialogue group: Losses and grief–what to do? Workshop: Body movements and self-care
Children's health	Dialogue group: Sociohistorical and psychological/emotional aspects and the scenario of children in situations of violence Minicourse: Vaccination Dialogue group: Disabled children Workshop: Malnutrition and food insecurity Dialogue group: Childhood obesity, biopsychosocial aspects
Women's health[a]	Dialogue group: Self-esteem and self-care, a sociological review of women's role in society, dialogues on patriarchy and gender equity Dialogue group: Women in situations of violence, types of violence at each stage of the life cycle Dialogue group: Domestic violence
Senior health	Workshop: General care and promotion of self-care (accidental falls, medication, skin care, and hygiene) Dialogue group: Mental health, depression and loneliness
Men's health	Dialogue group: Understanding, care, and self-care, why do men avoid seeking healthcare? Workshop: Alcohol and other drugs
Adolescent health	Dialogue group: Mental health and suicide Workshop: Alcohol and other drugs
Other topics covered	World Café: Healthy eating in times of the pandemic Complementary integrative practices – *Cuca Legal* (self-massage; meditation, yoga, Shantala, body-reflexive practices) Round-table discussions: PANCs (unconventional food plants)

[a]The authors refer both women's and men's health in the plural as they recognize the cultural, gender, sexual, ethnic-racial diversity that permeate the understanding of these groups, intersected by social markers of difference, with emphasis on the gender marker, but without ignoring the markers of race, age and social class

In July 2021, the project was evaluated by its participants for the first time. The partial result showed that, among the 28 respondents, 89.3% considered that the topics covered were relevant to their professional performance. The virtual/remote format was considered adequate, with live meetings and live streams made available on the YouTube channel. The performance of mediators and guests of each specific topic was mostly satisfactory and appropriate. Playful and artistic strategies were used throughout the project, with theatrical performances, which were widely well accepted and well evaluated by the CHWs. A messaging app was used to monitor and share written and audiovisual material, and the CHWs considered it to be reliable and of good quality.

Furthermore, in the CHWs' opinion, the topics addressed and the educational strategies adopted had a substantial impact on the reorganization of their work processes. In general, the CHWs considered the project to be a mechanism for appreciation and recognition of their work and role in the SUS; and in a specific report, one CHW highlighted how much he loves the TEIA project, as it has opened his

mind, showed him new paths, and encouraged him to seek new knowledge and know-how. Overall, according to the CHWs, the project helped to improve their mental health, self-care, and better planning of home visits.

A highlight in the project is the intersectoral approach reached through the partnership with the Federal University of Goiás, and the connection between the municipal, regional, and state levels, strengthening the management-precinct-university discussion, as well as promoting interdisciplinarity and interprofessionalism.

Among the difficulties and challenges found is the decrease in the participation of CHWs, especially in the second half of 2021, due to the intensification of vaccination against COVID-19 and work overload, where the support and action of the community health worker were essential to attract and mobilize the community. Another difficulty is related to poor access and poor stability of the virtual/remote connection, as many CHWs work in places with difficult access to the Internet, such as rural districts. As for the state management level, the head managers were unaware of the reality within the territory, and the State Health Department technical team was resistant to use active and innovative methodologies, in order to not break with a traditional and hierarchical logic in the conduction of their work aimed at supporting the institution and cooperating with the city halls in the SUS management. Thus, we faced a lack of knowledge and resistance to the collective and dialogical approach, listed by Freire's pedagogy (Freire, 1985, 1992) and present in the National Policy for Popular Education in Health (PNEPSSUS), established in 2013. Another challenge was the low incentive of financial and human resources to promote the actions and expand the project.

Take Care of Yourself to Take Care of Others: Promotion of the Unified Health System Workers' Health and COVID-19

In December 2020, as mentioned above, the 262 community health workers from the 8 participating cities received an electronic form, created on the Google platform, to survey the needs and issues related to health promotion that they consider a priority. After organizing the collected data, the promotion of the Unified Health System (SUS) workers' mental health was identified as the first topic to be approached with the community health workers, focusing on the issues and impacts of the pandemic.

Two matrix support strategy meetings were held to formulate and plan the "Worker's Mental Health" actions. The conducting group was composed of five community health workers, two health promotion technicians (state management), and two mental health technicians (state management). This smaller group took on the responsibility of building an agenda focused on the topic chosen and scheduled for April 2020.

The matrix support strategy meetings led to the subproject "*Cuca Legal*: Promotion of SUS Workers' Mental Health." This proposal is based on the perspective of the continuation of activities aimed at self-care of healthcare professionals working at SUS, via virtual classes and meetings. It includes the development of

integrative body practices, complementary integrative practices, lectures on self-care and mental health, and workshops on mental health at primary healthcare. The *Cuca Legal*: Promotion of SUS Workers' Mental Health subproject, which involves the promotion of integrative health practices and integrative body practices, has been developed in accordance with the National Policy for Integrative and Complementary Practices (NPICP), aiming at self-care and the promotion of people's autonomy through their relationship with their bodies.

The concept of care, as it is understood in contemporary times, is built on modernity and is linked to the process of objectification and regulation of bodies and subjects (Foucault, 2006, 2019; Agamben, 2017). For Foucault (2019), care of the self is an instrument of body control and political domination; thus, care is an element that regulates and disciplines its use.

Along the same lines, Butler (2015 p. 16) recognizes that the ontology of the body is a social one, since the "body is exposed to socially and politically articulated forces, as well as to requirements of sociability – including language, work, and desire – that make the body subsistence and prosperity possible."

Care constitutes a dimension of conforming to the values and ideals of a capitalist society, which arose in the middle of the eighteenth century from the European industrialization process:

> The sanitary reform that took place in Europe in the middle of the 19th century pledged to reorganize the living spaces of individuals. Its normative discourse conveyed the idea that low-income classes lived badly because they were saturated with immoral vices and because they lived without rules. The discourse of the dominating classes stated the need to guarantee the poorer classes not only health, but also a hygiene education and, through it, the formation of moral habits. (Soares, 2012 p. 08)

In modern society, self-care takes the place of deprival and abandonment of oneself (Agamben, 2017). Souza Santos (2020) highlights that neoliberalism (hegemonic model of the market) – supported by the capitalism, colonialism, and patriarchy triad – is a form of domination that uses measures of surveillance and control of the subjects through policies that regulate life and death. Therefore, care can be a strategy to make, or not, certain lives precarious and subject to disappearance (Agamben, 2017; Butler, 2015).

Redefining the perspective of care and self-care becomes an important strategy in the expanded conception of health and health promotion to make a radical change, because, as shown by the pandemic, the process of oppression admits inequities and the deaths of those who are seen as disposable. Care and self-care sometimes tend to be used in their functionalist and pragmatic versions and in the economic sense, which allows certain lives and populations to be disposable:

> These populations "can be discarded or sacrificed precisely because they have already been discarded or sacrificed; they are considered as threats to human life as we know it, and not as living populations that need protection from the State's illegitimate violence, hunger, and pandemics." (Butler, 2015 p. 53)

Nogueira, Rocha, and Akerman (2020) argue that raising discussions about the values that support our society means fighting a status quo that favors illness and, in a way, favors the virus in the pandemic scenario, instituting hygienist and (neo)

eugenicists practices, and death policies (necropolitics). Thus, for these authors, (re) politicizing the participatory and emancipatory political role of healthcare becomes crucial in dealing with the instituted political-economic model.

When addressing the care of SUS workers in the TEIA project, we identified that the topic is not limited to the prevention and maintenance of their health, but it includes the idea of strengthening the collective dimension, translating self-care into the care of others, that is, the care of the community, while advocating for understanding of fraternity and codependency. It starts from what Butler (2011 and 2015) calls the ethics of responsibility; by recognizing that one's survival depends on his relationships with others, measures need to be taken to preserve the lives of others.

Care practices are built from listening and dialogue, while emancipation practices stem from empowerment. By choosing "Promotion of the SUS Workers' Mental Health" as the starting point which led to the creation of "*Cuca Legal*," the construction of a critical reflection of human-nature and human-human relationships became evident (Freire, 1987). Mental health can be promoted through healthy and supportive human relationships, and by connecting with nature.

Active listening is essential for democratic and participatory practices and cultivates acknowledgment of the existence of others, creating a sense of belonging, acceptance, and respect.

The development of the dialogical self and the appreciation of listening is a healthy alternative to the persuasion, subjugation, and conquest of the other. Listening to the demands of the community health workers, recognizing their needs, and collectively developing an agenda that is based on a dialogical pedagogy and that aims to strengthen their potential and performance in their fields through the relation between self-care and care for the other represent an opportunity to transform and reformulate health. This is especially the case in the pandemic context, when there is a need to achieve equity and empowerment through health promotion.

New Directions, Reflections Under Construction, and the Reformulation of Education, Communication, and Health Promotion Practices

A year after the start of the new coronavirus pandemic, Brazil's political scenario of disconnection and systematization that corroborates the hegemony of a political-economic neoliberal-imperialist model makes local and community actions more fundamental than ever before, since only decentralized actions are capable of inciting social transformation.

In reference to Margaret Mead's quote above, a comment was made by one of the participants of CHWs' workshop who highlighted the fact that small groups of committed people are those who can change the world. The very same workshop, conducted using the World Café method (named by the conducting group of the project

as "*Café Cerrado*"[4]), led to the development of a booklet on "Healthy Eating: In Daily Life and in Times of Pandemic."

We remain dreamers and defenders of the ideals of the Unified Health System, as we understand that the pandemic requires us to act in health education, through connection and social participation. We believe that encouraging health promotion actions and practices is the way to transform the local reality, which will reverberate on a global scale, transforming the individual through the collective.

Additionally, the involvement of educators in teaching-service integration provides an opportunity to link scientific knowledge to popular knowledge as two aligned complementary fields, through dialogical and reflective methodologies. As explained by Souza Santos (2008 p. 88), "[the] modern science teaches us little about our way of being in the world," a new science, on the contrary:

> [...] knows that no form of knowledge is, in itself, rational; only the configuration of all of them is rational. Therefore, it tries to debate with other forms of knowledge, allowing itself to be penetrated by them. (Souza Santos, 2008 p. 88)

Regarding the COVID-19 scenario, Butler (2020 p. 62) highlights that the Sars-Cov-2 virus does not discriminate, but social and economic inequalities, supported by market rationality, do. The author says that "[the] virus alone does not discriminate, but we humans certainly do, by the intertwined powers of nationalism, racism, xenophobia, and capitalism."

Thus, the experience built in these 12 months demonstrates, as Giddens (2005 p. 84) points out, that the macro and micro dimensions are distinct, but intimately linked, as "interactions in micro-contexts affect larger social processes and macrosystems affect cases more restricted to social life." At the local level, the TEIA project is presented as a proposal of training and qualification for work processes based on the CHWs' autonomy and empowerment, fostering curiosity and questioning. According to Paulo Freire, rather than get answers, we first need to ask the right questions (Freire, 1985, 1992). Overall, considering the macrosystems, we dare to say that the project is subversive and radical. In the current times of crisis, not only in Brazil, but worldwide, it is clear that we live in a context of austerity policies, subtraction of social rights, and intensification of social inequalities, which are characterized by a management model that is based on the necropolitical model conceptualized by Achille Mbembe (Mbembe, 2016). TEIA seeks, based on Freire's concepts, to rescue humanity and love in times of denial, neoliberalism, and neocolonialism.

Furthermore, the fuel that drives the project is trust in the SUS journey. To paraphrase Eduardo Galeano, who cited Fernando Birri: "Utopia is on the horizon. I move two steps closer; it moves two steps further away. I walk another ten steps and the horizon runs ten steps further away. No matter how much I may walk, I'll never reach it. So, what's the point of utopia? The point is to keep walking" (Galeano, 2001). Based on that, the project could be continued and expanded, emphasizing two aspects: the CHWs' role and the elicitation of information from the precincts.

[4] Brazilian biome. The Cerrado is considered the Brazilian savanna, characterized by low trees with twisted trunks, widely spaced shrubs, and grasses.

The methodology can be replicated in other areas of management and assistance, where educational actions are proposed, in addition to primary care, throughout the Unified Health System/Public Health System network as well as other health systems in the global context. It should be emphasized that the prerequisite is the willingness of agents to listen to what is best for the precinct without prejudgment.

The thinking and reformulation of our human relationships is the opportunity to make the best out of the pandemic, strengthening social policies and the sustainability of health policies, supported by health promotion, using this digital and remote version of education and communication as spaces and places for the empowerment and emancipation of individuals, starting with health workers and expanding to the community. The proposal is in recognizing and appreciating cultural differences and diversity, as well as promoting equity and, finally, contributing, through dialogical and reflective practices, to the strengthening of the SUS and Brazilian democracy.

Table 12.4 brings our reflection on the six triggering questions suggested by the editors.

Table 12.4 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	We understand the headlight of health promotion (HP) is the health and is not illness, overcoming the biomedical paradigm. Health promotion is a field focused on collectivity and cares about the social, cultural, economic, and policy dimensions, as well as in the perspective of social determination. The HP has potential to encourage and to change, through the emancipatory education and the empowerment movement, the lives of people and their communities against the social exclusion and inequality relations and, by that, improving the democratic society
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	The experience addressed in this paper is the management and academia's response to the harsh reality uncovered by the COVID-19 pandemic. The TEIA project, Intersectoral Topics and Strategies with Community Health Workers, was created after the adoption of the digital communication strategy, through live streams with SUS health professionals and managers in the state of Goiás, as well as representatives of the community health workers. In January 2021, after surveying the demands and needs presented by some of the community health workers in the state of Goiás, a partnership was established with the Physical Education program of the Federal University of Goiás. Targeting the community health workers and other health professionals who work in Family Health and Primary Care teams, in the cities integrating the "São Patrício II" Health Region, the activities and actions will be carried out until November 2021

(continued)

Table 12.4 (continued)

Questions	Take-home messages
Which theories and methodologies are used in the teaching-learning process?	TEIA project is based on the dialogical and problematization methodology, referenced by Freire's pedagogical thinking, in the liberating perspective and the systemic theory, through the development of dialogical strategies and processes, as well as rotational leadership (Bojer et al., 2010) The stages of the project follow the logic of collective construction and shared management, involving community workers, municipal managers, technicians in the areas of health promotion and primary care, at the state level, as well as researchers and students (undergraduate and master's). Among the methodological strategies adopted, and based on the proposal of active learning methodologies, the World Café, round-table discussions, workshops, and dialogue lectures have been used
What kinds of forms of assessment are applied, results achieved and challenges faced?	TEIA is a pilot project taking place between November 2020 and November 2021, that is, over the period of 12 months. The project was born from a survey of the demands and needs of Community Health Agents, and it was structured into two axes: (1) the Unified Health System Workers' Health and (2) Comprehensive Care and Health Promotion, taking into consideration the stages of the human life cycle (childhood, adolescence, adulthood, and old age) as well as the gender perspective (women and men) The results were detailed, revealing a process of rupture with a conservative logic of maintaining routines and conditions. For this purpose, between May and October, 29 activities were carried out (virtual meetings, meetings with CHW conducting groups, short courses, and remote and in-person workshops) addressing sensitive topics suggested by the community agents in the activity planning and meetings organization, in addition to subjects related to each stage of the life cycle and from the gender and diversity perspective The virtual/remote format was considered adequate, with live meetings and live streams made available on the YouTube channel
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The project started from the recognition and appreciation of the precincts and their citizens, and the understanding of the crucial role of the community worker as an agent of change and social transformation. Therefore, it aims to promote empowerment and social participation through active and dialogical methodologies. The project also seeks to develop the sustainability of integrated and integrative public policies through educational and communicational actions and activities focused on health promotion and developed in an intra- and intersectoral manner. The project pillars are based on the education-communication-health promotion triad. The interdisciplinarity and the expanded concept of health were identified as necessary, considering the process of social determination and the impacts of inequities on the condition of life, work, and health, not only of the SUS workers but also of their community, as it revealed the existence of a cycle of precariousness and exploitation of life and subjectivity

(continued)

Table 12.4 (continued)

Questions	Take-home messages
What others could learn with your experience? What is localized and what is "generalizable"?	The project is an aligned, transversal, and interdisciplinary proposal, and its implementation emphasizes initiatives and actions that appear in the micro-social dimension as mechanisms of [re] existence and transformation through collaboration. Undeniably, there is a strong influence of the macro-social dimension, and the project does not ignore current global societal configuration, called by David Harvey the new "Imperialism." This is a period of deprivation, marked by the process of making human and work relations precarious. On top of that, we notice the uberization process and creation of austerity policies, especially in emerging and/or developing countries. The project is in line with the values and principles presented in the Agenda 2030 and the SDGs, especially SDG 10, regarding empowerment and the reduction of inequalities. Considering the transversal aspect of the proposal, the project presents interfaces with other sustainable development objectives, since it seeks to expand the health promotion actions in the precincts, highlighting the strategic pillars of Brazil's National Health Promotion Policy At the local level, the TEIA project is presented as a proposal of training and qualification for work processes based on the CHWs' autonomy and empowerment, fostering curiosity and questioning Furthermore, the fuel that drives the project is trust in the SUS journey. The methodology can be replicated in other areas of management and assistance

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Chapter 13
Professional Development in Health Promotion for Family Doctors: Using the "Entrustable Professional Activities" Approach

Rolando Bonal Ruiz and María Eugenia García Céspedes

Contents

Vision of Health Promotion

In Cuba, family medicine is called comprehensive general medicine. The vision of health promotion in this specialty has been guided by the definition included in the Ottawa letter and the Bangkok letter (WHO, 1996; WHO, 2005). It is stated as "the process that allows the person, family, group, community to have a greater control of the determinants of health."

Health promotion, which also incorporates the social determinants of health, consists of processes so that the family physician can advocate (defend), mediate,

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facilitate, and enable patients and providers to take greater control of their health status. This salutogenic vision is characterized by the social prescription of health assets for referral by family physicians of resources or well-being capacities. Health promotion covers primary, secondary, tertiary, and quaternary prevention approaches and aims to empower patients at each level of care.

Social and Political Context of the Experience (Participants, Professions and Courses Involved, Duration, and Frequency of Activities)

Family medicine has been defined in various ways by different organizations and scientific societies (Jamoulle et al., 2017). The European Society of Family Medicine/General Medicine, a regional branch of the World Organization of Family Physicians, defines family medicine through its 12 essential characteristics and 6 core competencies. The 12 characteristics include:

1. Medical contact within the health system, providing open and unlimited access to its users, taking care of all health problems regardless of age, sex, or any other characteristic of the interested party
2. Efficient use of health resources by coordinating care, working with other professionals in the field of primary care, and managing the interface with other specialties, assuming a role of defense of the patient when necessary
3. Developing a person-centered approach, oriented to the individual, their family, and their community
4. Promoting patient empowerment
5. Providing a unique consultation process, which establishes a relationship over time through effective communication between doctor and patient
6. Longitudinal continuity of care as determined by the needs of the patient
7. A specific decision-making process determined by the prevalence and incidence of disease in the community
8. Simultaneous management of both acute and chronic health problems of individual patients
9. Management of undifferentiated disease early in its development, which may require urgent intervention
10. Health and well-being promotion through appropriate and effective intervention
11. Specific responsibility for the health of the community
12. Dealing with health problems in their physical, psychological, social, cultural, and existential dimensions

Its six core competencies are primary care management; person-centered care; specific problem-solving skills; integral approach; community orientation; and holistic modeling (WONCA, 2011).

Family medicine has received various names in various countries. Some terms are *general practitioner* (UK), *hausart* (Germany), *huisarts* (Netherlands), *médecin généraliste* and *médecin de famille* (France), and *family physician* (USA). In Latin America, it is called *family and general medicine* in Chile and Argentina; in Spain and Brazil, *family and community medicine*; and in Peru, *comprehensive family medicine and health management*; in Cuba, it is called *comprehensive general medicine,* being inserted in social medicine and collective health. It is a clinical medicine with a strong biopsychosocial content (Cuesta Mejías LA, & Presno Labrador C., 2013), being closely linked to the principles of Cuban health system: socialist state character; preventive orientation; accessibility and general gratuity; integrity and development plans; unit of science, teaching, and medical practice; active participation of the population; and internationalism (Narey & Aldereguia, 1990).

As the gateway or cornerstone of the health system, the role of the family physician is based on the principles of the health system. The Cuban program of family medicine emerged in 1984, known as "Plan of the Doctor of the 120 Families." At the time, the physicians lived in the community with the nurse, forming a community team with basic health equipment to provide comprehensive medical care to an estimated 120 families that included an average of 700 people. The main objective of the program was to improve community health indicators through comprehensive actions aimed at the individual, family, community, and environment in close relationships with community members (Cárdenas et al., 2018).

The work of the basic health team (*Equipo Básico de Salud*, EBS, in Spanish) was complemented by a group of specialists in supervisory functions made up of clinical specialists in internal medicine, pediatrics, gynecology and obstetrics, and psychologists, as well as professionals or technicians in statistics, hygiene, and epidemiology and social work to support the specialists and form the basic work group (*Grupo Básico de Trabajo*, GBT, in Spanish) who regularly visit the family doctor's office, conduct consultations, and supervise tasks. Later, a family medicine specialist with clinical care and teaching experience was added to these GBTs.

Initially, the family physician program develops basic activities such as:

1. Continuous assessment and risk evaluation (registration and classification into groups of risk (e.g., healthy, at risk, sick, disabled)
2. Analysis of community health needs with intersectoral participation
3. Home visits to provide home care when a person requires daily assessment, rest, bed rest, or isolation
4. End-of-life care for patients with terminal illnesses
5. Group activities with vulnerable populations (e.g., older people aged over 60 years, adolescents, new mothers, pregnant women, patients with chronic conditions)

These activities represent singularities of the Cuban family medicine model from the beginning (Cárdenas et al., 2018). Community health analysis is the process by which researchers explore challenges and potential multidisciplinary interventions that may mitigate the risk of existing health problems, focusing on social

community participation and intersectoral cooperation. The problems are ranked by priority, and an action plan is prepared based on this systematic evaluation. This process is conducted by the family physician, nurse, community leaders, and representatives of community organizations, politics, and neighborhood sectors (health councils) (MINSAP, 2011).

Over time, some activities were halted, such as group activities, and others are not done with the required quality. In the family doctor's work program and in the specialty residency program, the "what should be done" was reflected, but it does not give details of "how to do it," especially in health promotion activities. It interferes in the physician's performance and in the motivation to do it. Many family physicians question the effectiveness of health promotion activities, and there is resistance to their implementation (Bonal, 2007).

To enhance health promotion skills of family physicians according to the needs of the Cuban population, the renewal of primary care in the Americas should emphasize prevention and health promotion (PAHO, 2007). The Cuban Ministry of Health aims to prioritize the founding principles of Cuban family medicine (MINSAP, 2021).

This should be done according to international conferences on primary care, especially the VII Ibero-American Summit of Family Medicine, held in Cali on March 13 and 14, 2018, which discussed the care of people's health, reflections of Latin American family physicians called to develop self-management of chronic noncommunicable diseases through self-care and personal empowerment (Bonal et al., 2017a) in Latin America, based on the Astana declaration of the second World Conference on Primary Health Care, which called for developing personal and community empowerment (WHO, 2019), and the increasing need to incorporate competency-based medical education (CBME) in the teaching of health sciences (WHO, 1996; Gonczi, 2013) from the recommendations of the letters and statements of the last world conferences on health promotion, due to the need to have an active approach to the social determinants of health to reduce social inequities according to the health promotion action plan of the PAHO for 2019–2030 (PAHO, 2019), which considers all the above.

For this reason, an educational strategy was developed to improve and update the health promotion of family physicians in a semirural municipality called *II Frente*, in the province of Santiago de Cuba, a municipality with 137 family physicians, including newly trained, resident of the specialty, and specialists in comprehensive general medicine. Not all family physicians work in medical offices, many are fulfilling international medical cooperation, and others are in other healthcare functions.

There are 53 family medical offices throughout the municipality that offer comprehensive care to the user. The strategy consisted, among other aspects, of making an initial diagnosis of health promotion performance, which was considered poor (Bonal, 2018). Once the problems and potentialities in the municipality were identified, training began. A total of nine family physicians were selected, all specialists in comprehensive general medicine with more than 20 years of practice in care, research, and teaching in health promotion; two had a master's degree in public health, one a master's degree in health promotion, two with diplomas in health

promotion, and one a master's degree in medical education. All had the teaching category of assistant professor and acted as experts to give their opinion on the educational strategy.

Identification and Development of Entrustable Professional Activities in Health Promotion

Eight training activities were delivered, including a workshop for the nine family physicians specialists in comprehensive general medicine, who acted as experts. The initial 2-hour workshop dealt with evidence-based health promotion in primary healthcare (Bonal & Marzán, 2012), an overview of the entrustable professional activities (EPA) approach (Olle Ten Cate, 2019), quality criteria for choosing a good EPA (Taylor et al., 2017), and an update in the work program of family physicians and nurses. The workshop was held at the Provincial Center for Health Promotion, where the main RBR author works. Health promotion activities based on scientific evidence of effectiveness were identified, which can be conducted by family physicians, equating them with the professional activities of health promotion that reflect in the work program of family physicians and nurses. A dynamic workshop on the CBME approach and EPAs was held as a way to operationalize this CBME.

Once the conferences were given, subgroups were held to identify the professional activities of health promotion based on evidence. RBR had previously researched, prepared, and brought to the workshop a group of evidence-based health promotion activities for the group to discuss and choose. The consensus method used in this workshop was the RAND/UCLA Consensus Method or "Appropriateness Method" (RAND/UCLA Appropriateness Method (RUAM)), which was developed by the RAND Corporation and the University of California, in Los Angeles, using scientific evidence and expert opinion (Fitch et al., 2001). Participants were instructed to send the proposals of the selected EPAs by email to the authors RBR, MEGC, answering the following question: what are the health promotion interventions based on scientific evidence of effectiveness that family doctors can routinely perform at individual, group-family, and socio-community level and that could constitute EPAs?

The experts used a scale of nine points to evaluate each intervention, which were classified as "appropriate," "inappropriate," or "doubtful." Once the "appropriate" ones had been identified, the essential EPAs were selected.

After the task was completed and sent by email, a meeting was called to refine the EPAs, adjust them to Taylor's criteria, and develop the full detail matrix of each EPA; this second meeting lasted approximately 3 hours (Taylor et al., 2020).

Four EPAs were identified, each one coinciding with the levels of individual, group, community, and social intervention (see Table 13.1). The way the workshop was conducted and the RAND UCLA method used to identify the EPAs is published online at a Medical Education Congress (Bonal, 2019a).

Table 13.1 Levels of intervention in health promotion and EPAs

Individual	Group/family	Community	Social
Lifestyle counseling	Group visits or shared medical appointment (group education) To patients living with chronic diseases Pregnant/parents Group well-childcare	Implementation of the community health council (intersectoral commission)	Addressing the social determinants of health to reduce health inequities

In the municipality *II Frente*, four workshops were offered, promoted by the health and government authorities of the municipality. An 8-hour workshop was aimed at the social actors of the community, local government, community, social and political organizations, presidents of Popular Councils and district delegates, social sectors of the community as representatives of physical culture and recreation, urban agriculture, representatives of local projects, etc. This workshop had the objective of encouraging and promoting community health councils (intersectoral commission), together with family physicians, protected by recent laws on the functioning of the Popular Councils, the local government, and the constitution of the republic that defends and promotes popular and community participation in the identification of local solutions to health problems (Constitution, 2019; Law 232, 2019). The content of the interactive workshop was based on knowledge on social and community participation, public health policies, community empowerment, salutogenesis, social determinants of health, social inequities in health, health equity, community assets, healthy communities movement, and the laws already mentioned. Negotiation skills were taught, how to conduct investment projects, how to identify community assets, etc. This workshop contributes to the performance of EPAs, "Carrying out the community health council (intersectoral commission)," "Addressing the social determinants of health to reduce health inequities," and promoting urban agriculture and systematic physical activity to ensure a healthy lifestyle.

A 4-hour workshop was aimed at health professionals and professionals from other sectors such as physical culture and recreation teachers and urban agriculture advisors. Workshop participants included professors of the basic working group (GBT), such as specialists in internal medicine, pediatrics, gynecology and obstetrics, and psychologists, as well as family nurses, pharmacists, physiotherapists, occupational therapists, podiatrists, health brigade (something like community health agents), stomatologists, specialists in natural and traditional medicine, and nutritionists. The content of this workshop consisted of raising awareness with interprofessional work and interprofessional collaborative practice on the competencies for teamwork and the role of each professional in the patient and health user education group in each period of life: childhood, adolescence, older adulthood,

pregnancy, preparation for retirement, women, and patients living with chronic conditions. This workshop contributes to the EPA activity of conducting group visits with interprofessional health and intersectoral participation (physical culture and recreation teachers and urban agriculture advisors). Group visits or shared medical appointments constitute educational group activities that are conducted in a dynamic, interactive, and dialogic way using the popular education method, conducted and facilitated by the family physician and/or family nurse, supported by other health professionals. The principles of health literacy and group rules are applied, and it contributes to the empowerment of the group.

In a section of the group activity, vital signs are measured and written in the medical records. These consultations do not replace the traditional individual consultation; they complement them.

A 2-day workshop was aimed at tutors and supervisors of the professional activities of family physicians who reside in the municipality. These teachers have the function of periodically supervising family physicians. Workshop content includes generalities of the CBME approach, the importance of this type of education and differences compared to traditional education, the EPA approach, EPAs in health promotion, different methods of performance evaluation in the workplace, guidelines for supervision of work activities of family physicians, observation guidelines, the frequency and periodicity of supervision, the entrustment scales, and how to use them.

For each identified entrustment professional activity, a dynamic, interactive, face-to-face theoretical course (approximately 8 hours) was conducted for 47 family physicians from the municipality, essentially at the workplace. Each week, the main authors of this text, together with the family medicine tutors/supervisors and those responsible for health promotion in the municipality, supervised selected offices to verify the level of performance (milestone) of each family physician. Professors and family physicians already trained would be in charge of training the other physicians providing medical assistance who had not received the training. For reasons of space, the performance levels (milestones) are not included in this text.

The general courses were offered only once, by two family physicians from the Provincial Health Promotion Unit, but it was repeated several times to family physicians by those responsible for health promotion in the municipality and family medicine supervisors/tutors. The course was also offered to new family physicians who were joining the municipality to work.

Detailed descriptions of each activity are set out in the Tables 13.2, 13.3, 13.4, and 13.5.

Table 13.2 Detailed descriptions of each entrusted professional activity of health promotion to family doctors – conducting lifestyle counseling

Title	Conducting lifestyle counseling
Specification	Lifestyle counseling can be described as professional guidance and support to help a person solve a problem. Healthy-lifestyle counseling involves guiding and helping patients to make changes in certain behaviors to reduce the risk of certain conditions, such as chronic noncommunicable diseases (acute myocardial infarction, stroke, and other diseases such as diabetes, noncommunicable diseases, and lung cancer) and sexually transmitted infections. The most frequent counseling that can and should be done in the family doctor's office is a brief intervention with a short interaction of 3–20 minutes between the health professional and the patient, the objective of which is to identify a real or potential problem, provide information about it, and then motivate and help the patient to do something about it. It involves two important aspects: the how and the what. The how refers to the communication style that the health professional uses to interact with the patient during the brief intervention, generally through motivational communication (Dragomir et al., 2020). The what refers to the structure of the counseling process and the content to be covered during the brief intervention (PAHO/WHO, 2019). Before every patient with a chronic non-communicable condition or before a risk behavior. The family doctor must find out if the patient wants to modify his behavior, explore the motivation or stages of behavior change in which he is, if he wishes to change, the barriers should be explored that make it difficult to make change and to overcome oneself, to draw up a measurable, achievable, realistic and timely action plan. All this process should be briefly reflected in the patient's medical history
Limitations	Patients with difficulties to understand (poor health literacy), patients with serious mental illnesses, patients in a precontemplation phase who do not want to change (low perception of risk)
Potential risk in case of failure	If the counseling is not conducted for any condition that requires it, the patient would maintain an unhealthy behavior, which would lead to complications and decompensations, for example, a smoking patient with chronic bronchitis and a diabetic patient who continues to consume sugary drinks and simple carbohydrates
Prevailing framework of competencies (professional profile)	*Educational teaching function:* The MGI is responsible for educating the patient and promoting self-care/self-management skills and healthy behaviors *Administrative function:* The MGI has within its responsibility to comply with the Family Doctor and Nurse Program and the Comprehensive Family Care Program, which has established comprehensive care for the person, including the promotion of healthy lifestyles *Investigative function:* Through motivational communication, behaviors can be modified, and the effectiveness of these techniques can be demonstrated through research in the local context of the clinic community *Function in special situations:* In exceptional situations such as disasters, earthquakes, etc., the motivational approach becomes vital for the fulfillment of actions

(continued)

Table 13.2 (continued)

Title	Conducting lifestyle counseling
Knowledge, skills and attitude, and experience	*Knowledge:* Counseling, definition, types according to time, according to content. Uses of counseling. Person-centered approach. Most frequent counseling models used in primary care. Model of the 5 A, of the 3 A; behavior change model, motivational communication. Uses, effectiveness. Chronic noncommunicable conditions and unhealthy behaviors or lifestyles, other unhealthy behaviors. Intensive counseling services in polyclinics, mental health centers, telephone counseling, and other services *Skills:* Skills for (1) reflective listening; (2) expressing empathy; (3) demonstrating acceptance, tolerance, and respect; (4) responding to resistance; (5) (not) judging or blaming negatively; (6) (not) expressing hostility or impatience; (7) provoking "change conversation"/evocation; (8) (not) being argumentative or confrontational; (9) setting goals; (10) being collaborative; and (11) providing information in a neutral manner *Attitude:* Open and respectful communication; attention to diversity (gender, age, culture); use of patient-friendly language; respect for the privacy and confidentiality of the patient; be aware of your own limitations and ask your supervisor for help appropriately and/or another more qualified professional *Experience:* The comprehensive general doctor's prior experience of counseling the patient based on intuition and traditional communication style
Sources of information or evaluation	It is evaluated through direct observation of the doctor's encounter with the patient, especially with a patient with risk behaviors, it is verified through the review of the clinical history, where the type of counseling and the exploration of motivation must be described, and its application must be reflected through a personal action plan. It is also evaluated through a problem case discussion in a teaching meeting with small groups, and asking the patient, through an evaluation by multiple sources or 360° evaluation
Expected level of supervision for this EPA	Lifestyle counseling is allowed without supervision, with remote monitoring
Expiration date (or period)	Not applicable

Theories and Methodologies Used in the Teaching-Learning Process

One of the authors of this text had already identified the health promotion competencies of a family physician in 2017 (Bonal et al., 2017b); however, these competencies were incorporated into each health promotion EPA mentioned in this text. The training sessions offered to family physicians were mostly based on the EPA approach, which constitutes an area that, in recent years, has developed in a dizzying way, both from a theoretical and methodological point of view. It is a concept developed in 2005 by the Dutch medical educator Olle Ten Cate (Ten Cate, 2019).

Table 13.3 Detailed descriptions of each entrusted professional activity of health promotion to family doctors – conducting group visits

Title	Conducting group visits
Specification	Group visits are spaces for group education, for the patient and the family and/or their caregiver, where essential guidelines (knowledge, skills) are provided that do not allow time to offer them in traditional consultations. A time is included in a section of the consultation to take vital signs: weight, height, blood pressure measurement, etc. Various sessions are offered depending on the condition or conditions treated. Chronic conditions are preferred to be treated generically, or multiple conditions at the same time, given the common denominators you have for those conditions, including risk factors. Group visits do not replace traditional consultations; they are an important complement to offer health education, information, and essential life skills and make the patient take greater control of the health decisions that affect them. Group visits – a combination of group education and clinical assessment by the medical health professional – is one of the components of foreign family medicine programs; it is cost-effective and has been shown to have scientific evidence of effectiveness. These group visits or clubs or circles or educational groups can be conducted with users with common characteristics: mothers of infants, pregnant women, adolescents, patients with chronic noncommunicable conditions, the disabled, etc. One day a month should be selected to conduct these consultations – prior appointment and adequate preparation – so that up to 20 participants meet in a suitable place in the community; participants must be registered as a healthcare activity, and health professionals must be notified and invited as facilitators and tutors
Limitations	Not all patients with chronic diseases will attend group visits, for example, disabled with disabling conditions, patients with serious mental problems, and health users reluctant to attend. Group visits are not a priority for the authorities of some polyclinics and the municipality, although they are identified at the national level as a priority for the year 2021: “rescue of the foundational concepts of the Family Doctor and Nurse Program” such as pregnancy circles, group well-childcare circles, chronic patient clubs, etc. Mother-infant and vector programs are prioritized Difficulty finding resources for teaching patients
Potential risk in case of failure	There are skills that are more likely to be taught in a longer time than the short time of consultations, and group spaces are ideal, for example, techniques for drug adherence and preventive measures, management of poly medication, assertive communication skills with family and healthcare providers, stress management, etc. If these skills are not taught effectively to the patient, these skills will be less adherent to treatment, the patient does not comply with the treatment, and there are greater adverse effects due to drug interactions, inadequate communication with health providers, etc.
Prevailing framework of competencies (professional profile)	Carrying out group consultations is associated with the five functions of the comprehensive general practitioner, reflected in their professional profile, such as comprehensive medical care (by holistically attending to the patient and their family or caregiver), teaching educational (when applying the role of health educator and teacher), administrative (when managing a group visit and a multidisciplinary team), investigative (when using the results and impacts of the consultation for investigative work), and special (making use of education group in special situations)

(continued)

Table 13.3 (continued)

Title	Conducting group visits
Knowledge, skills and attitude, and experience	*Knowledge:* Health promotion, health education, differences. Group versus individual education. Personal and group empowerment. Theory of popular education. Theory of self-efficacy. Differences between regular traditional education and participatory education (self-care/self-management). Principles of adult education, health literacy. Situation of chronic noncommunicable diseases and the maternal and child care program in the world, Latin America, and Cuba. Chronic care model of the World Health Organization. Group visits/shared medical appointment/team appointment/group care, definition, historical background in the world and in Cuba. Uses, types, schedule, methodology, and effectiveness *Skills:* Interpersonal and group communication skills, establishment of group rules, skills for group dynamics. Skills to use participatory techniques of presentation, analysis, animation. Skills for interprofessional teamwork (nurse, internist, pediatrician, podiatrist, physiotherapist, psychologist, professor of physical culture, etc.). Self-management skills of chronic conditions by the patient (handling of self-monitoring devices, glucometer, sphygmomanometer, etc.; management of polypharmacy; management of emotional symptoms, stress, anxiety, anger, etc.; management of physical symptoms, pain, fatigue, dyspnea). Skills to make a personal action plan, goal setting. Skills and techniques to achieve therapeutic adherence. Skills to control planned consultations for pregnant women and nursing mothers *Attitude:* Open and respectful communication; attention to diversity (gender, age, culture); use of patient-friendly language; respect for the privacy and confidentiality of the patient; be aware of your own limitations and ask your supervisor for help appropriately and/or another more qualified professional; adherence to group rules and schedule; use of ethical principles of communication; respect for the members of the health team *Experience:* The previous experience of the comprehensive general doctors is to have done individual education in traditional consultations, to guide the patient, mainly using health information
Sources of information or evaluation	It is continuously evaluated during the supervision of the basic work group (GBT) through direct observation of the activity, exposed in the supervision guide (checklist). The reflection of the group visits in the clinical history of the patients, in the registration sheets of patient care (charge sheets). Presentation of cases. Once the doctor performs the activity optimally, he/she will be able to supervise other colleagues with less expertise
Expected level of supervision for this EPA	Group visits are allowed without supervision, with remote monitoring
Expiration date (or period)	There will be a period of 6 months, after which if the doctor does not conduct the activity; after investigation of the causes and limitations, he will reconsider, and if the limitations are not conclusive, it will influence his/her performance evaluation

They are defined as the essential tasks or activities that a specialist in their care area must develop, once they demonstrate that they are reliable and competent to perform those tasks without supervision. An EPA should have the following characteristics: being a task of great importance for daily practice, requiring knowledge, skills, and attitude; giving rise to recognized results in the subspecialty or specialty;

Table 13.4 Detailed descriptions of each entrusted professional activity of health promotion to family doctors – implementation of the community health council

Title	Implementation of the community health council
Specification	The community health councils are regular meetings (once a month), where the family doctor and nurse meet with the social actors of the community; they attend to identify and analyze the health situation of the community. The social actors are made up of the delegate of the circumscription (local government); the representatives of the social, community, and political organizations of the neighborhood; the representatives of institutions and work centers within the community; and informal opinion leaders who can contribute to troubleshooting. These meetings are inextricably linked to the report and process of identification, diagnosis and analysis of the health situation (ASIS) of the community, process where problems are identified, prioritized and the solutions to priority problems are monitored and controlled through the action plan . There will be times that due to emergent situations, social actors will be mobilized and summoned outside of the planning of the established sessions
Limitations	Some polyclinic decision-makers do not even support family doctors to hold this type of meeting, a schedule that coincides with the available work time of each social actor, generally in the afternoon, when working; the family doctor does not live in the same community as the patients; some doctors have stage fright to hold a cross-sectoral meeting; there are insistence of some key leaders and social actors, lack of institutional pressure on grassroots leaders to stimulate participation, and lack of motivation from both health professionals and social actors; some communities in the practice do not completely coincide with a constituency; some have more than one constituency with more than one delegate However, there are alternative solutions for these types of limitations, and the new government laws and the constitution support this type of meetings
Potential risk in case of failure	Community health problems alone are solved effectively with the coordinated, conscious, participatory, and sustained action of community social actors. If not done, environmental risks would be maintained for a longer time; the solution of health inequities and social problems that influence a health situation would be delayed
Prevailing framework of competencies (professional profile)	*Comprehensive healthcare function:* the comprehensive doctor is responsible with health users to determine the health status of the health population by analyzing the health situation with social and community participation through the community health council *Educational teaching function:* The comprehensive doctor trains community leaders to develop health education and promotion activities *Administrative function:* The comprehensive general doctor performs intersectoral coordination for the solution of health problems, putting into practice what is established in the family physician and nurse program as well as the Comprehensive Family Care Program *Investigative function:* Applies the scientific method in the process of identification and solution of the health problems identified together with the analysis of the health situation with social and community participation *Function in special situations:* In exceptional situations such as disasters, climatic changes, earthquakes, and floods, intersectoral participation and coordination is most needed in these cases through the community health council

(continued)

Table 13.4 (continued)

Title	Implementation of the community health council
Knowledge, skills and attitude, and experience	*Knowledge:* Health as a social product, social participation, community participation, healthy public policies. Community empowerment. Social determinants of health. Social inequities. Government structure in Cuba, territorial units, municipality, Popular Council, circumscriptions. Community, definition. Health diagnosis; analysis of the health situation, intersectoral cooperation, teamwork, health "assets," salutogenic approach, social prescription, risk communication: community health council or health committee. Definition, members, functions, schedule, methodology, effectiveness. The community health council and the healthy environments and healthy communities movement *Skill:* Group and community communication skills, establishment of group rules, skills for group dynamics. Skills for risk communication, principles of risk communication (create and maintain trust, recognize and communicate even in situations of uncertainty, coordinate, be transparent and fast with the first and all communications, be proactive in public communication, engage and interact, etc.). Skills for intersectoral teamwork (social actors of the community, presidents and representatives of social, community, and political organizations, etc.). Skills to prioritize problems and establish a participatory action plan, intersectoral to each priority problem. Skills to conduct a monitoring and follow-up evaluation. Skills to perform an outcome and impact evaluation. Negotiation skills (capacity for self-knowledge; self-control; capacity for empathy; ability for active listening; assertive, argumentative, and persuasive ability; nonconfrontational ability; frankness; authenticity; trust; flexibility; risk tolerance; adaptability) *Attitude:* Open and respectful communication; attention to diversity (gender, age, culture); use of friendly language for social actors; respect for the privacy and confidentiality of the matters dealt with; altruism and social justice *Experience:* The comprehensive general doctor's previous experience of holding meetings with non-health personnel
Sources of information or evaluation	It is evaluated through the direct observation of the group meeting of the doctor and the family nurse with the social actors of the community, it is complemented with the verification of the meeting minutes (audit) where the signatures and position appear of each participant, and the matters dealt with in each meeting and the essential aspects of the community council are verified with a checklist, through an evaluation by multiple sources or 360° evaluation; it is verified through the interview with the stakeholders and their contributions to the meeting
Expected level of supervision for this EPA	It is allowed to conduct community health councils without supervision, with remote monitoring
Expiration date (or period)	Not applicable

being performed by qualified specialists; being executable within time limits; being conducted independently by the apprentice; being observable and measurable both in their process and results to draw conclusions (whether it is reliable/not reliable); and expressing more than one competency. Health promotion activities are an

Table 13.5 Detailed descriptions of each entrusted professional activity of health promotion to family doctors – addressing the social determinants of health to reduce health inequities

Title	Addressing the social determinants of health to reduce health inequities
Specification	The social determinants of health are the circumstances in which people are born, grow up, live, work, and age, including the health system; they are also considered as the set of personal, social, health, economic, and environmental factors that condition the health status of individuals and the populations in which they live. Examples of social determinants are the socioeconomic environment which includes income and social status, social support networks, education, employment and working conditions; social inclusion and non-discrimination, neighborhood and physical environment. Other social determinants of health are: healthy child development, personal health practices, individual capacity and coping skills, biology and genetics, health services, gender, and culture and others. Differences in the people of these determinants constitute health inequalities; when they are unjust, modifiable differences, they are called health inequities. Health promotion is the process that allows people to take control over modifiable health determinants, including social determinants. The family doctor is in a privileged position as a social and community leader to influence social actors in the community and in decision-makers to reduce social inequities through the social prescription of health goods or assets and health advocacy
Limitations	Although family doctors intuitively influence the community to solve social problems, sometimes they do not have tools such as the social prescription of health assets, nor do they have internalized the salutogenic approach to health. The health authorities of the polyclinic may not understand the health advocacy and health prescription approach and interfere with the doctor's work
Potential risk in case of failure	The psychosocial problems of the patients are often derived from the differences in the social determinants of health; they are also solved with nonmedical resources. There are resources or goods, also called assets for health, which are factors or resources that improve the abilities of people, groups, communities, populations, and/or institutions, are useful to maintain and sustain health and well-being, and help to reduce health inequalities. If the health assets approach is not applied, and the doctor does not prescribe it (social prescription), or apply health advocacy, these psychosocial problems will persist longer; these problems would be medicalized, which have a nondrug solution; therefore, it would increase the cost and health expenditure
Prevailing framework of competencies (professional profile)	*Comprehensive medical care function:* The comprehensive general doctor as part of its comprehensiveness identifies the social determinants of health that influence health and produce inequities *Educational teaching function:* The comprehensive general doctor educates, advises, guides, and refers vulnerable patients and families with social inequities to help resources and community wellness assets; the doctor advocates for the health of their patients, families, and community *Administrative function:* The comprehensive general doctor complies with the Family Doctor and Nurse Program that prioritizes care for vulnerable users and disadvantaged conditions *Investigative function:* The comprehensive general doctors can, as an investigative function, measure and evaluate the result and impact of its interventions on social inequities in health *Function in special situations:* Exceptional situations such as disasters, earthquakes, heavy rains, etc. become prone to act with vulnerable families and apply tools of social prescription and health advocacy

(continued)

Table 13.5 (continued)

Title	Addressing the social determinants of health to reduce health inequities
Knowledge, skills and attitude, and experience	*Knowledge:* Social determinants of health (SDH), definition according to the WHO, WHO model, Cuban model, social inequalities in health, social inequities in health, concepts and differences, social prescription, health assets, concepts, applications, health advocacy, concept, applications *Skill:* Integration of knowledge in the identification and approach of SDH in the person and family with unfavorable living conditions. Apply reflective, critical, and experiential learning in the approach to SDH. Apply transformative learning in the approach to SDH *Attitude:* Empathy, open and respectful communication, understandable communication, attention to diversity (gender, age, culture), respect for privacy *Experience:* The comprehensive general doctors' previous experience of intuitively indicating "non-pharmacological" treatment
Sources of information or evaluation	It is evaluated through direct observation of the report of the analysis of the health situation, the family medical history, and the individual medical history, where the doctor reflects the different SDH. The individual medical history of the patient is observed, and it is verified if the doctor identifies the health inequities derived from the health determinants and if he prescribes health assets and practices health advocacy. Through an evaluation by multiple sources or 360° evaluation, patients are asked about the doctor's prescriptions beyond drug treatment; colleagues are asked about the comprehensiveness of the doctor in that sense
Expected level of supervision for this EPA	It is allowed to approach the SDH to reduce health inequities without supervision, with remote monitoring
Expiration date (or period)	Not applicable

essential part of the responsibilities that the family physician should have at a personal, group, and family level in the community and in society.

According to the work program of the family physician in Cuba, health promotion is the guiding activity of family medicine (MINSAP, 2011) in this approach, which was first developed in the postgraduate area for specialization curricula in surgical clinical medical residencies, being increasingly extended to other health sciences, such as nursing, pharmacy, and the preventive and public health area. It is also used in undergraduate areas and improvement activities, even outside the human health area, such as in veterinary medicine.

EPAs are little used in professional development and continuing medical education/continuing professional development. But in Cuba, the existence of experienced tutors and supervisors, both in family medicine and as family physicians working in managing departments of primary care and health promotion, guarantees the phased fulfillment of the competence. However, it is still necessary to sensitize, internalize, and train more in this approach so that it can be developed with maximum effectiveness. The EPAs arose to close the gap between competences (knowledge, skills, attitude, values) and practice, since the competences taught are often too theoretical and abstract and do not correspond to the actual performance

of the learner. In this sense, EPAs constitute an effective way of operationalizing competency-based education or training. The acquired competences can only be expressed through the resolution of complex tasks, being expressed in actions. The educational theories underlying health promotion training offered to family physicians include the Malcolm Knowles' theory of adult education or andragogy and its assumptions: adults are independent and self-directed, they accumulated a wealth of experience that is a valuable resource for learning, they value learning that is integrated with the demands of their daily life, they are more interested in immediate problem-focused approaches than in topic-centered approaches, and they are more motivated to learn by internal impulses than by external ones. The aforementioned reasons for the need to update and improve the performance of family physicians in health promotion were motivations for joining the course (David & Hamdy, 2013).

Experiential learning theory consists of learning by doing and implies that students move away from theory to focus on practice. In this sense, the four-step cycle by David Kolb was followed, i.e., abstract concepts are developed from experience and approved from concrete experiences to observe and reflect on the experience (David & Hamdy, 2013).

An attempt was made to apply this theory in all EPAs by making the family physician learn and reflect on this practice. The principles of Cuban medical education were used, such as education at work, linking study with work, and theory with practice (Salas et al., 2017).

Forms of Evaluation Applied, Results Achieved, and Challenges Faced

The EPA approach is a form of evaluating the competence (knowledge, skills, attitude) of a health professional in a given field through professional performance. EPAs are observable and therefore evaluable through workplace-based assessment instruments. In our case, we evaluated knowledge through questionnaires administered before and after the training sessions; and abilities and skills through observation guidelines and checklists prepared ad hoc or through medical audits if the professional health promotion activities appeared in the records of professional activities of the family physician; attitude through an instrument called 360-degree evaluation or evaluation of multiple sources, also known as comprehensive evaluation, which seeks a perspective of the performance of family physicians as comprehensive as possible, with contributions from the perception of patients of health promotion activities and of social actors of the community. We verify if patients received educational guidance under the principles of health literacy and if they received behavioral counseling on lifestyle. Social actors and key community representatives are asked about their participation in community meetings or encounters with family physicians, if they identified community problems, and if they

participate in the intersectoral action plan. We verify if the rest of the allied health professions participate collaboratively in the group educational sessions (group visits). Validated instruments are also used, such as the Mini-CEX (Mini-Clinical Evaluation Exercise), which consists of direct observation of professional practice for about 20 minutes, with an evaluation structured by a checklist that shows the elements of competence and gives subsequent feedback to the family physician in the next 10 minutes. Some of the competencies evaluated in this instrument are the skills for motivational communication with the patient and behavior change in the event of an unhealthy lifestyle (Norcini & Burch, 2007).

The reflective portfolio was used to evaluate the practical approach to social determinants of health. After 3 months there were changes in the knowledge, skills, and attitude of the family physicians according to the instruments administered before and after the training received.

However, there are some preliminary results:

(a) Complete descriptions of each EPA in health promotion have been written, including the knowledge, skills, and attitude required, serving as a guide for teachers, tutors, supervisors, and students.
(b) Greater knowledge and skills acquired by family physicians based on scientific evidence of effectiveness.
(c) Methodologies are drafted on how to conduct the practice of each professional activity entrusted to health promotion.
(d) "Community health councils" and "lifestyle counseling" were implemented in most of the family doctor's offices in the municipality.
(e) Some indicators for evaluating the work performance of family physicians were written, including the performance of these EPAs.
(f) The EPA on "Practical approach to social determinants of health" was approved by the National Group of Specialists in comprehensive general medicine to teach it to second-year residents of the specialty, with a basic teaching text being written for that purpose.

Challenges faced: Not all assessment instruments have been nationally validated nor do they meet the Ottawa criteria for good assessment in health science education (medical education) (Norcini et al., 2011). Not all tutors, supervisors of family medicine, are familiar with the EPA approach, nor do they have the skills to lead and conduct an observational guide. As it is an experience of an isolated municipality, the lessons learned from this experience may clash with the traditional teaching-learning method used nationally. Health promotion in family medicine is much more than these four entrustable professional activities, these EPAs summarize the essential and representative activities, additional EPAs may be needed, or it may complement teaching with traditional training in a hybrid way. Although in the municipality where the experience was carried out by the heads of the municipal health promotion department, teaching authorities, professors, and tutors spoke the same language in the teacher evaluation, this may not happen in other

municipalities, since most officials of municipal health promotion departments are not physicians or nurses, nor do they understand well the particularities of health promotion in the clinical setting of family medicine; thus, they may not feel motivated to evaluate it and do not include it as part of its functions. However, periodic visits to the municipality of the authors of this manuscript and the main professors of the experience are maintained to monitor compliance with what was taught and to guide family physicians and tutors.

Principles, Pillars, Competencies, or Approaches to Health Promotion That Based the Educational Strategy for Improving the Health Promotion Performance of Family Physicians

All the "EPAs" taught in our course meet all the guiding principles of health promotion suggested in the book by Rootman et al. (2001). "They are empowering (enabling individuals and communities to assume more power over the personal, socioeconomic, and environmental factors that affect their health); participatory (involving all people concerned at all stages of the process); holistic (fostering physical, mental, social, and spiritual health); intersectoral (include collaboration of relevant sector organizations); equitable (guided by a concern for equity and social justice); sustainable (bringing about changes that individuals and communities can maintain once initial funding has ended); and multi-strategic (using a variety of approaches — including policy development, organizational change, community development, advocacy, education, and communication — in combination)."

Specific health promotion competencies are used in family medicine, being identified by the main author of this experience (RBR) in 2017 (Bonal et al., 2017b). The three pillars of health promotion are used and served as thematic areas at the ninth World Conference on health promotion held in Shanghai, China, in 2016 (WHO, 2017): (1) good governance: family doctors were trained to empower their users to choose "healthy, accessible, and affordable options"; (2) health literacy was the basis of all training (Bonal et al., 2013); and (3) development of "healthy communities" through the creation of intersectoral commissions (community health councils). An integrative performance model in health promotion was used (Bonal, 2019a), including the best of the international performance approaches conducted by family physicians (Bonal, 2019b; Naidoo & Wills, 2016). The five fields of health promotion actions were also present in the training process, according to the Ottawa letter (WHO, 1996) (see Table 13.6). The three strategies, advocate, mediate, and empower, are highlighted with more emphasis in the EPA "Addressing the social determinants of health to reduce health inequities," which would lead to reduced health inequities and achieve health equity and greater well-being.

Table 13.6 Relationship between "EPAs" in health promotion and the five fields of action according to the Ottawa Charter for Health Promotion

	"Entrustable professional activities" in health promotion	Five fields of action according to the Ottawa Charter for Health Promotion
1	Lifestyle counseling	Developing personal skills: provide people with information and education, improve life skills, and allow them to cope. Personal empowerment
2	Group visits (group education) to patients living with chronic diseases, pregnant women, well-child visits	Developing personal skills: providing people with information and education, improving life skills, and enabling them to cope. Group empowerment
3	Community health council (intersectoral commission)	Developing healthy public policies: putting health on the agenda of all policies in all sectors and at multiple levels Creating healthy or health-friendly environments, safe living and working conditions that are stimulating, satisfying, and enjoyable Strengthening community action: work to ensure that communities set priorities, make decisions, plan strategies, and can implement them to achieve better health. Community empowerment
4	Addressing the social determinants of health to reduce health inequities	Three health promotion strategies: advocate, mediate, and empower individuals, families, peer groups, and communities to reduce health inequities and achieve equity in health and well-being

Transferability and Generalization of the Educational Experience

The local experience has been applied in a municipality of a province inland. It can be used in other municipalities in the country. Also, part of the courses, workshops, PowerPoint presentations, self-evaluation questions, supporting bibliography, evaluation methods, etc. are located in the virtual classroom of the university of medical sciences where the authors belong, with access restricted to apprentices. The training can be generalized to any scientific society of family medicine or any regulatory entity that wishes to reproduce or be inspired by its methodology, according to its academic interests. As far as we know, according to searches conducted in databases of medical and health literature, there are no similar experiences at the international level to compare. It could be justified since Cuban family medicine has a highly social and intersectoral approach; the "community health councils" are an activity more localized and typical of the Cuban health system. However, the rest of the EPAs in health promotion (lifestyle counseling, group visits (group education), practical approach to the social determinants of health) are more generalizable to other family medicine systems in other countries with this EPA approach.

Table 13.7 brings our reflection on the six triggering questions suggested by the editors.

Table 13.7 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	The vision of health promotion in Cuban family medicine (comprehensive general medicine) conforms to the definition given by the Ottawa letter and the Bangkok letter (WHO 1986; WHO, 2005): process that allows the person, family, group, and community to have a greater control of the determinants of health – including the social determinants of health. It includes processes so that the family doctor can advocate (defend), mediate, facilitate, and enable its users (not only patients) to take greater control of health
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	The teaching experience is developed in primary healthcare centers (polyclinics and family doctor's offices), in a rural municipality called *Segundo Frente*, belonging to the province of Santiago de Cuba. The training is aimed at family doctors. Family medicine in Cuba is called "comprehensive general medicine," being a clinical medicine with a high psychological and social content. The principles of Cuban family medicine are clinical care to the person, family, group, and community in a holistic and comprehensive way; social, community, and intersectoral participation, interprofessional collaboration; state and social character, accessibility and gratuitousness of services, orientation to the promotion of health and the prevention of diseases and other damages to health, internationalist medical cooperation, humanisms. The participants in the health promotion teaching and learning process were mainly family doctors; members of the basic primary care work group (internal medicine specialists, pediatricians, obstetrician-gynecologists, physiotherapists, physiatrists, psychologists, occupational therapists, podiatrists, physical culture teachers, urban agriculture advisor)
Which theories and methodologies are used in the teaching-learning process?	The workshops and training offered were based on competency-based training, which is operationalized through the EPAs. Among the educational theories used are adult education, popular education, experiential learning theory, and others
What kinds of forms of assessment are applied, results achieved and challenges faced?	The forms of assessment applied were formative assessment, especially based on direct observation of the professional practice activity that constitutes the EPAs in health promotion and constant feedback to the family doctor, in a constructive way. The main assessments are the EPA-based assessments, which answer the question: "can we trust the trainee to execute EPA X without supervision?" Entrustment decisions combine traditional assessment of ability with the right to execute an EPA without supervision (or with indirect supervision only). In an educational context, entrustment decisions mean decisions to trust a learner with an essential professional responsibility at a specified level of supervision. There are "Ad hoc entrustment decisions," situated in time and place and based on estimated trustworthiness of the trainee, risk of the situation, urgency of the job to be done, and suitability of this task at this moment for this learner, and "Summative entrustment decisions," grounded in sufficient evaluation and made by educational program directors or made and recognized by a relevant supervisory team (Ten Cate et al., 2016; Ten cate & Taylor, 2021)

(continued)

Table 13.7 (continued)

Questions	Take-home messages
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The health promotion teaching and learning experiences aimed at family doctors were based on the principles of health promotion according to Rotman (Rootman et al., 2001): they are empowering (they enable individuals and communities to assume more power over personal factors, socioeconomic and environmental that affect your health); participatory (involving all stakeholders during all stages of the process); holistic (promote physical, mental, social, and spiritual health); intersectoral (include the collaboration of organizations of sectors); equitable (guided by a concern for equity and social justice); sustainable (they bring about changes that individuals and communities can sustain once the initial fund has been used up); and multi-strategic (they use a variety of approaches – including policy development, organizational change, community development, advocacy, education, and communication – in combination) The experience used health promotion competencies in family medicine, previously identified and developed by the lead author in 2017. The five fields of action and the three basic health promotion strategies reflected in the Ottawa letter were used too (OMS, 1986)
What others could learn with your experience? What is localized and what is "generalizable"?	They could learn the authorities of family medicine and health promotion of other municipalities and other provinces. Family medicine scientific societies from other countries, interested stakeholders, health promotion working groups of family medicine scientific societies, and interested teacher training groups

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Part III
Innovative Pedagogies for Health Promotion

Chapter 14
Introduction to Part III: Innovative Pedagogies for Health Promotion

Diane Levin-Zamir and Julia Aparecida Devide Nogueira

Chapter 15 introduces wikis as a tool for engaging health promotion students through relational pedagogy and cooperative learning. Students work together in small groups to create a wiki, based on what they have learned, and collaboratively curate online wiki content guided by assigned tasks that cover key learning concepts. Practical insights and reflections from teachers and students regarding the assignment and its utility for collaborative learning are then integrated with theoretical and practical knowledge to envisage the potential for relational pedagogy. The capacity for relational wiki work increases student engagement, support students' writing and paraphrasing skills, and build health promotion competencies.

Chapter 16 acknowledges that education itself should be transformational through student-centered learning activities related to theory, practice, and the integration of the two, aiming social transformation. Grounded in theoretical knowledge about what supports students' deep learning, innovative methods, such as team-based learning, the aim is for students to acquire higher-order thinking skills that have transformational potential. This chapter addresses the endeavor of structuring and developing innovative pedagogies within and across three modules, to facilitate health promotion education at master's level for graduate health promotion specialists.

Chapter 17 describes the process of translating and adapting a traditional medical teaching strategy, the journal club, into the field of health education as a creative method to develop professionals' information literacy in a master's program. A journal club for the literature review phase is practice for organizing an action plan,

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but it also constitutes a way to share emergent knowledge on health education in one's own community. The matrix method practice with a guideline for journal club management has been designed and produced, as well as an evaluation questionnaire and tutorial meetings for the evaluation. Participants are highly satisfied with this participatory methodology.

Chapter 18 reports on the experience of simulation of medical care, since the development of technical skills, attitudes, and knowledge (such as communication, leadership, assessment of needs, care planning and evaluation) can be simulated, providing an effective, controlled, and safe option for learning clinical skills. Home visits and consultations are addressed, using professional actors who participate in the formative evaluation of the students, through the exposure of their perspectives and their feelings about care, with scenarios that vary in complexity and learning goals in a humanized and patient-centered manner, stimulating reflection and critical thinking.

Chapter 19 reports on the experience of developing a teaching project based on the students' experience with a group of skateboarders to discuss health promotion practice within the community. Using the photovoice method, skateboarders produced a photographic survey and reflective narratives about the relationships between the urbanization process and health promotion, becoming true teachers of health promotion theories.

Chapter 20 describes the cultural perspective of health and well-being focusing on the experience and reflections of two Māori health promoters who transitioned in academic teaching. They look back on their journeys in health promotion academic teaching and offer advice and direction to our younger selves. The chapter shares two letters informed by their unique cultural, political standpoint and experience in health promotion and public health. One author shares her experiences as a Māori health promoter and how this influences her public health teaching practice today. The other writes of the transition from social justice activist, to health promoter, to activist scholar and what this might mean in the classroom.

Chapter 21 focuses on participatory research skills adopting methodologies supported by action-reflection-action in health promotion in undergraduate and graduate courses taught by professionals from diverse expertise. The eight modules, taught through face-to-face workshops, based on community-based participatory research (CBPR), focused on the dimensions of power, individual and community empowerment, partnerships, indicators, and evaluation. Participants stated satisfaction with the course and the acquired skills needed to face their own community projects. The methodology was successfully converted to a virtual environment in 2021 showing good results within hybrid configurations and community representatives and social movements.

Chapter 22 presents experience in forming a network in Brazil's northeast to address regional inequities in the context of primary healthcare (PHC). Active methodologies are adopted for capacity building. Quanti-qualitative indicators measure impacts related to the acquisition of competences and applied knowledge in professional practice. Evaluations show that the methodologies, especially formative and networking, are meaningful for the knowledge and the strategy described.

Chapter 23 shares the accrued experience in undergraduate teaching in four different courses in Brazilian federal universities. The teaching and learning experience was based on participatory approaches using different strategies such as team-based learning, the circle of health, and the Charles Maguerez arc. The classes are described and present conceptual and methodological convergences in adopting approaches that highlight the interrelationship between theory and practice, and prioritized intersectoral settings. Challenges to this approach were identified and analyzed, and opportunities for strengthening health promotion teaching/learning are detailed and developed. Analyses showed that what is taught underpins health as a social value and incorporates health promotion pillars such as those described in national and global policies.

Chapter 24 describes the development of postgraduate health promotion courses at an Australian University based on health promotion challenges at the local, regional, and global level. For a diverse student body, the complexities of planetary health presented a unique opportunity to develop innovative pedagogical practices to develop a range of skills to meet these challenges. History, the competencies, and frameworks shaped the pedagogies developed to support students to integrate theory into practice. A nested approach was designed for in-depth application with assessment, reflexive practice, and blended learning and teaching to engage students and support ethical, culturally competent health promotion practice.

Chapter 25 also presents a postgraduate course, offered as an interprofessional initiative in Curitiba, Brazil. The authors share a special case study on virtual learning, building in a 20-year trajectory. Special importance is given to the theories and methodologies used and evaluative challenges in the teaching-learning of health promotion.

Chapter 15
Wikis in Micro-Communities: A Collaborative and Relational Learning Tool for Health Promotion

Eva Neely, Victoria Chinn, Emma Jones, and Tali Uia

Contents

Introduction

As a discipline, health promotion is critical and equity-oriented with a vision for social transformation (Taylor et al., 2014). Health promotion aims to pursue social justice, shift power relations and collaboratively work towards better improved individual and collective health. Health promotion is therefore ideally anchored in critical pedagogies to ensure graduates are 'practice savvy, socially conscious, politically astute' (Sendall, 2021, p. 5). As such, health promoters must be trained to work directly with diverse communities, stakeholders, partner organisations and other health professionals in such a way that is collaborative, inter-sectoral, participatory and empowering (Hall, 2014).

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Given this role of collaboration, it is pivotal for health promotion practitioners to be well trained in relational skills. Though not directly named, we can identify the ubiquity of relational skills needed in the IUHPE core competencies that provide international guidance for the development of health promoters (International Union for Health Promotion and Education, 2016). Relational skills are implicit across the nine core competencies (enable change, advocate for health, mediate through partnership, communication, leadership, assessment, planning, implementation, evaluation and research). For example, to 'mediate through partnership', one must have skills in 'stakeholder engagement', 'collaborative working', 'facilitation and mediation', 'communication skills', 'networking' and the 'ability to work with stakeholders across diverse community groups'. At a local level, we can equally identify relationship building as an underlying competency across the nine clusters of practice and driving values in the Health Promotion Competencies for Aotearoa New Zealand (Health Promotion Forum, 2012). Health promotion practice in Aotearoa New Zealand recognises 'interdependence' as a central value that emphasises the interconnectedness between individuals, families, communities and the broader environment.

Whilst *whanaungatanga* is difficult to translate, the term embodies the importance of relationships in Māori culture (Indigenous peoples of Aotearoa New Zealand). When considering the needs of Māori, building relationships grounded in trust, reciprocity and time are crucial determinants of good practice (Mead, 2003). There is little point trying to pursue collaboration without a relationship because of the underlying trust that is required. Given the pivotal role of relational skills for health promotion globally, and in particular for working locally in Aotearoa New Zealand, there remains a gap in practical tools and pedagogies in building these relational skills, and consequent collaboration, amongst health promotion students (Madsen et al., 2019).

Relational Pedagogy

In this section we describe our pedagogical approach to teaching health promotion. Fundamentally, we draw on relational pedagogy which assumes for learning to take place, human beings need to meet and interact over a period of time in such a way that builds relationships (Bingham & Sidorkin, 2004). This allows us to account for relational, embodied and performative actions and see pedagogy as an ontological practice that 'situates and unsettles knowing' and seeks opportunities for more in-depth ways of relating to others in learning (Timperley & Schick, 2021). Timperley and Schick describe how such pedagogical practice can help students develop a better understanding of themselves in the world and reflect on how their lives intersect with others. Such an approach has immense value for health promotion where we seek to realise pedagogies that prepare our students to 'acclimatize to multifaceted and swiftly moving contemporary milieu infused with evolving social consciousness and implied social decrees on a stage of neoliberalist ideologies, bureaucratic inaction, and political rhetoric' (Sendall, 2021, p. 5).

A relational pedagogy sees knowledge as co-constructed in social interaction (Bingham & Sidorkin, 2004). The teacher and learner therewith become active co-creators in the knowledge generation process as both bring their own sociopolitical backgrounds into the learning. Situating learning as a social process requires intention to foster relations between and amongst teachers and students, and can facilitate 'coming-to-know' ourselves, our perspectives and our taught content (Lave & Wenger, 1991). As a discipline that desires social change and requires practice-oriented competencies, moving beyond objective and surface-level knowledge production is desirable, and we require pedagogical tools that facilitate relational and embodied ontologies to emerge from health promotion learning (Madsen et al., 2019; Sendall, 2021).

Knowledge acquisition can happen through reading, listening, watching, sensing and talking. Through interaction with others, we contextualise, relate and deconstruct knowledge. However, it can be challenging to practise relational pedagogies in large classes, where the time and scope for academics to build relationships with their students is limited. Small discussion groups are a common tool used to engage students in course content and enable them to develop ideas in more depth. Such groups are effective for content contextualisation but rely less on the relations between students due to their irregular configuration (Loh & Ang, 2020). To address this shortcoming, Schick (2020) discusses the use of micro-communities to create class environments in which students can build relationships in a small group over a semester. The intention is to enable students to develop relations and trust as they learn about, and with, each other. In such a context, students are more likely to feel safe to share their thoughts, doubts and queries with known peers. This practice strongly draws on relational pedagogy and supports students whose cultures value collectivism and interactional ways of learning, taking a welcome departure from rationalist Western pedagogies (Schick, 2020). In Aotearoa New Zealand, this approach may be particularly valuable for Māori and Pasifika students for whom *whanaungatanga* (broadly referring to relation), *manaakitanga* (broadly referring to care for, and value in each other) and *rangatiratanga* (broadly referring to self-determination) in learning need to be considered (Juliet et al., 2017; Sciascia, 2017).

Collaborative Learning and Wikis

Collaborative learning in higher education complements relational pedagogy as it involves shared learning between and amongst students and teaching staff. According to Barkley, Cross and Cross (Barkley et al., 2014), learning is truly collaborative when students equally contribute to the workload and engage in meaningful learning. In this case, meaningful learning occurs when students work together to extend and/or deepen their knowledge of the learning objectives. This type of learning is associated with many positive outcomes, including improvements to cognitive learning, student engagement and personal development (Barkley et al., 2014; Smart & Csapo, 2007).

A wiki is an interactive and convenient online learning tool that enables collaborative learning (Cubric, 2007; Kao & Chen, 2013) through a user-generated platform (Doherty, 2008). Wikis are open, dynamic and simplistic, which make them flexible and user-friendly for collaborative learning (Schwartz, Clark, Cossarin & Rudolph, 2004). More specifically, wikis are browser-based allowing users to post, create content and comment instantaneously (Parker & Chao, 2007) and address barriers of distance and time in the online learning environment (Su & Beaumont, 2010).

Wikis have been used in teaching as a way for students to record their thoughts (e.g. reflective assignment), collaborative writing (e.g. literature review) and as a knowledge repository (Parker & Chao, 2007). Wikis are reported to promote effective collaborative learning and formative assessment by enabling quick feedback, learning through the observation of other students' work, ease of navigating content (Su & Beaumont, 2010) and improving writing skills (Haidari et al., 2020). By creating a shared wiki, students can feel increased psychological ownership over their learning (Luo & Chea, 2020).

However, these tools are not without their limitations. Su and Beaumont (2010) have noted that some students with learning impairments (e.g. dyslexia) report barriers to using wikis. Irregular access to digital devices and/or Wi-Fi connectivity can also impede effective student engagement. In regard to relational development, the online environment is also limited by the type and quality of interactions; social cues in body language and verbal inflections that are typically observed in the classroom may not come across on an online platform. These limitations can constrain the relational benefits of collaborative work and ability for teachers to track student contribution, engagement and learning (Major, 2015). Therefore, factors such as accessibility, student contribution and communication must be carefully considered in assignment planning and delivery. Nonetheless, wikis enhance opportunity for the exchange and co-creation of knowledge between students.

The Wiki Assessment

This assessment is situated in a second-year 'foundations of health promotion' course offered annually at a large urban university. Students studying the health promotion major must complete the course to earn a Bachelor of Health. The class size sits typically at 45–50 students and is taught in on-campus lectures and tutorials. Our wiki assessment sees students work in small groups to develop a wiki that captures key learning across the semester. By working with micro-communities (Schick, 2020) and drawing on relational pedagogy, this assessment aims to enable students to keep up with their readings, support each other and learn through interaction. The tutorials in this course are delivered weekly (12 tutorials at 1 hour). Weekly tutorial time is dedicated to team building and wiki work. Beyond taking ownership over their own learning (*rangatiratanga*), the groups also serve to foster

manaakitanga and *whanaungatanga* between students to create a sense of belonging and forge friendships. Additionally, the wiki serves as a useful revision tool.

In the first week of teaching, students complete a learner assessment form that indicates their learning preferences, needs, strengths and challenges. This information is used to construct groups (4–5 students) within tutorials, which forms their micro-community across the semester. The rationale for the matching is to enable students with different strengths and challenges to support each other. Whilst the primary task at hand is driven by the weekly wiki entries, the secondary purpose shared with the students was to enable them to build a small network of support.

In the first tutorial, we share the wiki assignment with the students, where they meet their groups, engage in relationship building icebreakers and choose a group name. They are also asked to draw an image of their group that includes their group name, drawings of each group member, their names and personal fun facts about themselves (see Fig. 15.1). They are asked to draw each other, which facilitates their engagement with, and learning about, each other. Using arts-based practices enables students to interact in a relaxed way and produce a small tangible product at the end. Following this activity, each micro-community introduces their group to the rest of the tutorial, establishes a communication channel and then follows instructions to set up their wiki. Padlet (padlet.com), an open-source, user-generated Web 2.0 platform, is used for the wikis (see Fig. 15.2). Students sign up; one member creates

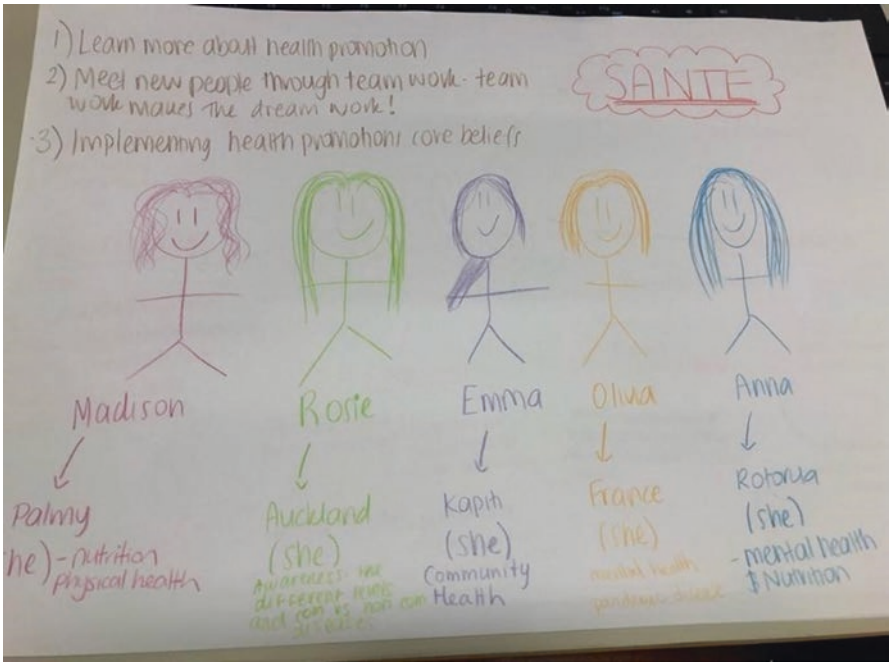

Fig. 15.1 Drawing of the Sante wiki group

Fig. 15.2 Example of wiki Padlet page

the wiki page and invites the other group members. This activity involves further creativity and shared decision-making which supports relationship building. Students are asked to divide the five modules and assign a leader for each. The module leaders are not responsible for doing all the work, but rather support and encourage group members to write their entries. The leader is also responsible for editing peers' work, which exposes them to co-editing.

Across the semester, students receive time in every tutorial to work on their wikis. Each week students receive key points of lecture content as a guide (e.g. Fig. 15.3). They are also able to use photographs, videos, images and voice memos in their entries, which offers diverse ways to capture content, depending on learning needs and skills. Students are graded at the end of the term such that 75% of their mark assesses completeness of the wiki (inclusion of key points) and 25% is based on peer- and self-assessment of their group contributions.

Insights and Reflections

In this section each author reflects on their experience of the wiki work. The first author (EN) developed the course and is still involved in teaching the course; the tutor and students were present in the first 2019 running of the course.

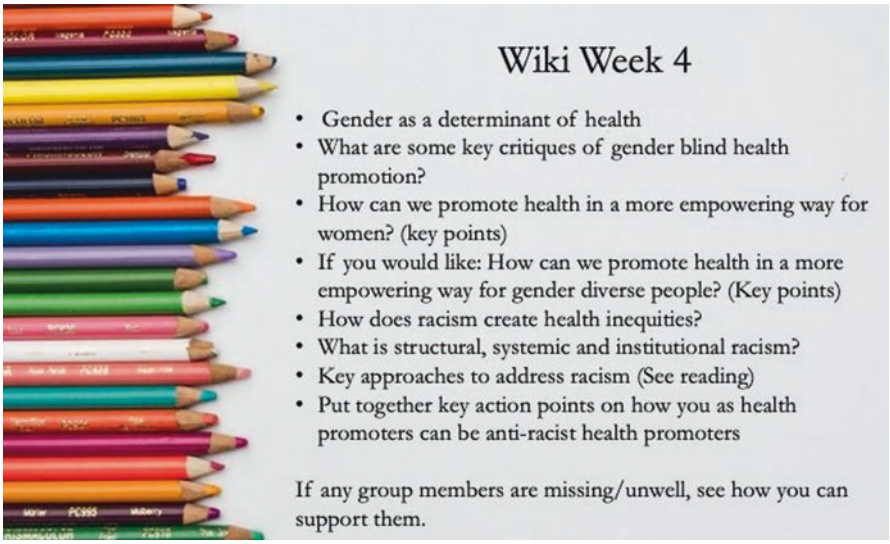

Fig. 15.3 Example of weekly wiki guidelines for students

Teaching Perspectives

Lecturer Insights (EN) For me a fundamental building block to the success of this assessment is the initial investment in my own relationship building with students. Through building a personal connection to students in the first weeks of the semester, I aim to build an environment of care and reciprocity. To achieve this I need to open myself up to my students, which involves sharing personal stories (including failures). This personal investment and opening up impacts on the class culture, with students sharing their personal stories in relation to the subject matter and enabling affective learning practices to unfold. In connection with the reflective journal (one of the other course assessments which includes five entries), students are prompted to develop deep thinking skills about core health promotion values, ideas and challenges.

Working interpersonally does not come without challenges. Some students are not used to working in this way and can feel uncomfortable opening up to new people. Not allowing students to self-select groups means that some are dissatisfied they cannot be in a group with their friends. The wiki group work was also different for many because, contrary to past university group work they had done, this work lasts across a semester and is less geared towards one large outcome. Rather it is more concerned with the process of engaging and continuously working together for small products, such as capturing key points from a reading or filtering the most pertinent ideas from a theory.

As a teacher in a world in which students' performance at university is often very grade-oriented, the wiki assessment offers a mechanism by which I can engage students and encourage them to read and write beyond their core assessment work, which contributes to a more holistic understanding of the learning objectives.

I have observed how students become co-learners and teachers in the moment. They learn through their own relations with each other, through the openness and vulnerability they bring to these situations of trust. For the success of this assessment, it is necessary to give students time during tutorials to encourage dialogue and task them with targeted activities to learn about each other. As a Pākehā (NZ European descent) teacher, it is important to find ways in which I can support Māori and Pasifika students to seek traditional and collective ways of knowing that I am not privy to. Alongside the inclusion of Māori and Pasifika readings throughout the course, as well as my own open positioning as Pākehā teacher, the wiki work enables students to develop a collective learning and dialogue space. From my experience so far, the group environments and topics also mean students often share more of their identities with each other. I am cautious, still, that it is important to keep all students safe in the course. But the relational approach we adopt has meant my tutor and I have been more aware of the group dynamics and needs of students.

Across groups there has been variation in how much students rely on each other, and in their approach to teamwork. An astonishing revelation from this experience has been that even those students who did not have the most fulfilling and reciprocal experience, generally reflect on this experience as one that built their skills and ability to work in groups. Thus, even the groups that arguably do not get the trust, reciprocity and friendships out of their wiki group as I hope, report a valuable learning experience. I do believe their simultaneous development of reflective thinking supports their critical thinking of themselves, which contributes to these insights they develop.

One of the most striking memories I have from the first year I taught this class was how a student told me that this had been the first time she had had the opportunity to make friends with her health degree cohort. It had enabled her to make lasting friendships that carried on beyond the course. Students would also support their group members to catch up on work if they had been out of action for personal reasons and supported their peers in their wiki work if they were not able to. The wiki groups thus acted as small networks of support for students. Importantly, the wiki groups created a more equitable support network for students in the course because not only those who had managed to make friends themselves had support they could rely on.

Tutor Insights (VC) As tutor, I witnessed how the group dynamics and wiki assignments evolved over the semester. Each tutorial comprised dedicated time to the wiki assignment in which students could connect with their groups, share highlights and challenges with me about working as a group, devise a plan for the upcoming week and work together on their wiki. I was also privy to student insights about working in their groups based on direct communications (via emails or post-tutorial conversations) and student reflections about their peer groups at the end of the semester.

I took care to support each group's autonomy by adopting a facilitative role guided by a neutral and strengths-based perspective. This meant that when discussing any challenges, I would help students brainstorm possible solutions and highlight what they were doing well, but it was ultimately up to the group to decide how they wanted to move forward based on the ideas they generated. Some groups wanted more guidance than others. Leaving space for students to 'figure it out on their own' felt uncomfortable at times, but was critical to prompt students to reflect on their situation, take ownership as a team and problem-solve as a group. So, whilst uncomfortable at times, placing students in the 'driver's seat' was critical to supporting students to genuinely engage in effective collaborative learning.

Based on the reflections at the end of the semester, the students described how the wiki assignment supported them to develop effective ways to communicate (between team members, using different technologies and paraphrasing key ideas), prioritise tasks, manage their time, listen to others and learn from each other's perspectives, engage with and learn from peers with different strengths (working styles, personalities, lived experiences), practise leadership, trust others, build a repository of content knowledge for future reference, and collectively build experience and confidence working in a group. Students also learned how to ask for help, overcame preconceived fear/dislike of working in groups and identified when to step up and when to loosen control. It was also evident that students supported each other through busy and difficult times and formed new friendships.

It became apparent that some groups collaborated better than others; some groups found the assignment difficult. Examples of these challenges included groups not communicating outside of the tutorials, members not attending tutorials and/or unequal contribution to the wiki between members. In contrast, some groups found it easy to work together highlighting streamlined communication, ease of task delegation and equal contribution between members. Reflections at the end of the semester revealed that, despite the differences in group cohesion, most students learned valuable lessons about working in groups. Students discussed learning about their personal strengths and weaknesses of working in a group and how they came together with others (effectively or not). Thus, regardless of group cohesion, students gained valuable knowledge relevant to working with others in the future.

Based on my observations, the duration of the wiki assessment and the Padlet platform were important factors for building collaborative skills amongst the students. Working on the assessment over the semester created ample learning opportunities for students. For example, groups discussed identifying effective ways to communicate with each other (e.g. channel, time of day, frequency), providing and receiving constructive feedback, dividing and prioritising tasks between members (e.g. leadership, time management), negotiating different working styles, and trusting others to follow through with their tasks and listening to each other's perspectives. The formative nature of the wiki assessment provided an opportunity for students to regroup during each tutorial and explore what was working well (or not) over the semester. Therefore, students were able to learn how to work together more effectively over time. Such learning would be constrained by shorter timeframes.

The Padlet platform was also an important component of the assignment that heightened opportunity for collaboration between group members. The easy-to-use interface provided a convenient space online that students could access outside of tutorial time and on equal terms – meaning each member had the same opportunity to contribute. Additionally, each student could express their personal learning through different types of media allowing other group members to learn from individual learning styles and creativity. The platform's flexibility allowed each group to customise their wikis by theme, content, structure and colour. From a tutor perspective, these features enabled individual members to form a group identity and consolidated ways of working together.

Student Perspectives

EJ (Student) Insights I gained new skills during this assessment, which also helped me increase my engagement with the course content. Using collaborative learning created a safe space for me and allowed my group to learn together about new concepts. At the beginning of the course, I was nervous about doing group work. However, the experience shifted my views on collaborative learning. I learnt a lot about myself during the assessment; for example, I enjoyed taking a leadership role, which I had not had the opportunity to prior. The group conversations helped me gain insights into different worldviews, which also shifted my understanding of how people's sociocultural backgrounds shape how they view the world we live in. In addition, the group work increased my engagement with readings.

The assessment gave us more responsibility for our own work. In working collaboratively with other students, there was a sense of commitment to the work, and attending tutorials paid off by working on the wikis during this time. The time spent in tutorials helped me build a good relationship with my tutor. In addition, the tutor came to the group with a neutral position, allowing us space and time to test ideas and ask questions in a safe space.

I developed my individual skills by sharing my strengths with peers but also working on my weaknesses. We did a questionnaire at the beginning of the course, which encouraged me to analyse how I learn best and what I wanted to improve. This prompt allowed me to reflect on my learning style, and I was then purposely placed in a group where we had different strengths and weaknesses. I gained new reading skills through summarising key themes collaboratively with my group, constantly reflecting on my positionality. I also gained public speaking skills through sharing ideas with the class during tutorials, where I felt supported by my peers. I liked this approach as it served as a tool to collaborate and learn.

Another skill that I developed through the course was working collaboratively with others. Working with other individuals is a fundamental skill and had been rare in my university experiences. The wikis became a platform for knowledge sharing

between the group and supported my learning journey. In addition, working with a group allowed me to experience real-world challenges. For example, when one student had to leave for a week, the group could communicate to ensure the work was completed for her. Stepping in when challenges arose increased the connections we built in our group.

I am now working in a government agency, where my team relies heavily on information sharing, communication and relationship building. Having been exposed to wiki work in my studies prepared me well for knowing myself when navigating this complex new environment as a new staff member. I learned invaluable skills for working in health promotion through the wikis, not only for working with others, but also the knowledge I developed through the wiki work was much more cemented. I am now studying towards my Master of Health and frequently look back at the wiki throughout my learning journey.

TU (Student) Insights It was not until reflecting on the course that I realised the true value that I gained from this assignment. Whilst the wiki work explicitly forced us to reflect on the learnings each week, it was the more implicit lessons and learnings that were the most meaningful and have remained with me to this day.

The wiki assignment was different than any other assignment I had during university. Often university assignments are individually targeted; this means the planning, execution and ideas you include are decided by you. Being in my second year of study, I had unconsciously formed a rigid individualistic working style that I used across my courses. The wiki assignment is truly collaborative and relies on consistent communication, connection and collaboration with those in your group. During the wiki work, I was challenged collaboratively and organisationally. The reliance on collaboration for the wikis forced many of us out of our comfort zones we had built. This resulted in significant feelings of discomfort due to not being entirely in control of the work being produced. It was this discomfort that distracted me (at the time of writing the wiki assignment) from the useful learnings and discussions which this assignment provoked.

Wikis required reflection, discussion and consolidation of each week's key learnings within your group. This meant I reflected on my understandings of the key health promotion values but was forced to discuss this understanding with a wider group of diverse individuals. Open discussion exposed me to different perspectives. A specific example I remember is that a member of my group brought a strong Māori background and perspective to the course. Through working with him, I saw how his worldview affected his outlook on the different topics we covered, which broadened my own perspective. Alongside this growth, working with a group of diverse individuals each bringing their own experiences and perspectives also invoked reflexivity on my positionality. Understanding how my experiences, background and culture influence my worldview is vital as it impacts how I do work and the assumptions that may underlie the decisions or conclusions I draw as an individual or professional.

Beyond the actual course learnings, this assignment taught me a lot about myself and how I function in group work settings. I did not realise at the time as a student who had transitioned from high school straight to university, but the ability to work effectively in a collaborative environment is vital for transitioning into a work environment or even just into postgraduate studies. Understanding how I respond in group collaborative work will be important to ensure I can be a successful team member in the workforce. Wiki work required high levels of collaboration; during this assignment I realised how unfamiliar and uncomfortable I was with collaborating. Knowing that I have these weaknesses was an important initiator that enabled me to work on them.

Discussion

This chapter sought to explore how collaborative wiki micro-communities could, on the one hand, enhance student engagement and improve learning and comprehension and, on the other hand, develop students' relational skills and broaden their worldviews towards becoming competent future health promoters. Reflections from the teaching team and students revealed that the wiki work can bring about benefits to students' learning and engagement, develop their sense of connection to their classmates, challenge their perspectives and comfort in individual learning experiences and develop skills that they can take out into the workforce.

The student insights revealed how the wiki assignment had positively impacted on their engagement with the course materials and learning topics. Emma describes how her knowledge of health promotion concepts became more 'cemented' over time through ongoing engagement with her wiki assignment. This engagement is seen as discussing and writing concise summaries of the readings with her group each week. She also engages with the assignment by referring back to the wiki as a knowledge repository, as she builds on these core health promotion concepts into her Master of Health studies 2 years later. The wikis also promote student engagement through relations. Tali mentions how reflecting and discussing course content with her group peers helped consolidate her learning by analysing core concepts through a variety of perspectives. Likewise, Emma notes how the group element of the assignment fostered a sense of increased commitment and attendance. These insights coincide with findings that quality relationships play an important role in cooperative learning outcomes such as knowledge retention and higher-level reasoning (Johnson et al., 2014).

Micro-community wiki work can develop collaborative skills over time, highlight barriers to working in groups and expose students to learning more about themselves in a team context. The nature of much university study is about individual performance, where 'competition and individualism are, by definition, at odds the values of collaboration and cooperation' (Mutch & Tatebe, 2017, p. 227).

Students learn to be reliant on themselves only, as holders of their own responsibility in succeeding at university. This assessment challenges the individual-oriented mindset and pushes students into unknown territory that can feel uncomfortable. Some revert back to carefully dividing up tasks and do not manage to feel at ease with being out of control in outcomes. But as Tali writes above, even if you are less comfortable with this, the experience of this assessment helps develop that insight about one's self. The exercise can also highlight one's enjoyment for collaborative work, such as Emma discovering her enjoyment in a leadership style role. Integrating assessments like the wiki work into courses can offer opportunity to steer students away from individualised work and support them to work cooperatively and realise that shared control over university work can have benefits, as well as challenges. As such, collaborative and enduring relational wiki work can contribute towards less individualised assessment outcomes that are simultaneously also more conducive for Māori and Pasifika students for whom the Western neoliberal university can pose multiple barriers (Waiari et al., 2021). Furthermore, the skills and awareness the students gained from working in their micro-communities underpins competencies that are essential to being successful health promoters. Relinquishing control and trusting others to work collaboratively are pertinent to skills that seek to enable, advocate and mediate for others.

The wikis exposed students to a broader range of perspectives. Different students bring out different key points based on their own identity and experiences. Hearing about a student's worldview prompts peers to reflect on their own thinking. In this way, relation enables reflection through interacting with others in a safe space where everyone is learning together. This space enabled peers to discuss new perspectives and acknowledge that it's okay to not know everything. Above, Tali talks about her revelation in coming to know how a fellow student conceptualised a reading from a Māori perspective quite differently to her, and identified how her different sociocultural background has shaped the key points she took from this reading. Students thus learned about their positionality in minute practices situated in their learning journeys. This observation echoes what Orland-Barak (2006) sees as divergent dialogue, in which people depart from their own personal meanings to confront others' values and beliefs through conversation. We can draw parallels from Orland-Barak's study to speculate that collaborative wiki work in micro-communities may enable students to develop broader perspectives through divergent dialogue. Although we can only draw on anecdotes here, it is also likely that students were also able to engage in parallel dialogue (Orland-Barak, 2006), a dialogue with themselves, through the frequent opportunity to engage with peers in their idea development. In this course we cover topics such as racism, sexism and neoliberalism, and given some students experience an expansion of their perspectives through the wiki work, it is possible that we could more explicitly draw on postcolonial pedagogy in helping students dismantle hegemonic knowledges (Thielsch, 2020). Future research could explore the potential for such dialogue-driven approaches to help students critique and dispute their own ideologies in a safe environment.

In an era of increasing online teaching and learning, it is furthermore critical to emphasise the role relational pedagogy can play in the 'classroom'. Whilst our course is mostly taught on-campus, the COVID-19 era has brought about flexibility for our students to learn off-campus as well. In 2020, we also had a few wiki groups who attended a zoom tutorial and whose groups were more online than in-person; however, this was somewhat muddled because not all zoom tutorial attendees were off-campus and were still able to connect with their group members in-person. Nevertheless, this tool still holds promise for an online learning environment, and possibly offers a means to make students from afar feel more connected with some of their peers (Barber et al., 2013). Because of the online platform, students can build their wiki from anywhere. However, we did observe that online groups could become very transactional such that members divided the work and then pursued this individually without much further interaction. It would be important to support these online students to interact in their online tutorials (e.g. zoom breakout rooms or equivalent) towards building their relationships through true collaborative learning.

The 'success' of the group dynamic was variable, and not all groups loved the experience. Given this variety of group dynamics, it is imperative to find the right balance between creating enough space for group autonomy yet providing adequate guidance to ensure students are supported to complete their assignment. The tutor's ability to check in with students throughout the semester is an important mechanism, which mirrors Thielsch's (2020) idea of 'listening out' for students as they figure out this different way of learning. This reflective process with the tutor enabled students to learn from their collaborative experiences through trial and error, a process deemed critical when working with others (Wallerstein & Bernstein, 1994). Thielsch (2020) recommends including a mechanism for students to critically reflect and share their experiences of this learning. In our course the fifth reflection acts as an outlet for students to share and reflect on their experiences across the course, including the wiki group work. We recommend such an opportunity sit alongside the support throughout the semester for students.

The open wiki instructions each week made some students feel a little insecure about 'what' and 'how much' was expected of them. It is conducive for students to manage such uncertainty in small portions of their courses and develop some dependence on each other, and confidence in themselves, to determine what should be deemed 'important' enough to include. We marked students for completeness of their work on topics across the course (through the topic bullet lists). We read their entries, ensuring that all students had contributed, and with that marked their contributions towards a learning module as complete. This openness in deciding what to highlight or include on various topics enables students to develop their health promotion voice without a fear of judgement, and invites students to pursue knowledges they see as most pertinent (Waiari et al., 2021). As students, people are developing their scholarly selves; they come to know the discipline through their

engagement with, and reflection on, subject knowledge. In this journey students may find themselves 'in (academic) situations that challenge the values of this community or its epistemological convictions, the construction of otherness may be provoked to (re)assure the accuracy of one's own perspective' (Thielsch, 2020, p. 236). In her work with music students, Thielsch discusses how postcolonial pedagogy can help students develop a sense of 'otherness' in the process of becoming academically acquainted with their disciplines. Sustained and frequent conversations that draw on students' different perspectives can support them to develop as critical scholars of their disciplines.

It is important to consider the whole course environment when integrating such assignments. As a teaching team, we fostered trust and relationships throughout the course and see this assessment as embedded within such a teaching and learning culture. When teachers embark newly on such a journey of relationally informed pedagogies, it is useful to find another academic as an ally and support for this work, to closely consider and monitor students' anxiety around the unknown and personal and to be as open and transparent as a teacher about the journey you are taking them on (Thielsch, 2020).

Conclusion

Student and teacher reflections revealed that the wiki assessment nurtured student engagement and relational skills linked to core health promotion competencies. The wiki assessment aligns with the perspective that the health promotion workforce must be trained using teaching and learning methods that are empowering (Hall, 2014). This was achieved in our course demonstrated by teachers adopting a supportive and facilitative role that enabled students to engage in learning that was self-directed and relational.

Aspects of the wiki assignment that were critical to supporting these outcomes were the micro-communities that the students engaged in over the semester, creating an intentionally relational environment throughout the course (teaching pedagogy and practice, assignment design, delivery and evaluation), and the access and versatility that the wiki platform provided. The wiki assignment and respective insights that contextualise the assignment reported in this chapter offer a useful tool for educators that seek to foster relational and collaborative skills in future health promoters.

Table 15.1 brings our reflection on the six triggering questions suggested by the editors.

Table 15.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion as a discipline is critical, equity-oriented with a vision for social transformation. Health promotion aims to pursue social justice, shift power relations and collaboratively work towards better improved individual and collective health. Health promotion pedagogy is therefore anchored in critical pedagogies to enable, mediate and advocate for and with our students. Health promotion is by nature also collaborative and interdisciplinary. Therefore, health promoters must work directly and effectively with diverse communities, stakeholders, partner organisations and other health professionals in such a way that is collaborative, inter-sectoral, participatory and empowering (Hall, 2014)
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	We are situated at a large university in the capital city of Aotearoa New Zealand. Our socio political and cultural context is situated in a Western and neoliberal environment. We have a Bachelor of Health with a specialisation in health promotion, as well as postgraduate health promotion programmes. The course in which the assessment takes place is a second year course; for the students this is their first substantial introduction to health promotion. The class size sits at about 50 students and runs through weekly, on-campus lectures and tutorials (although in 2020 due to COVID-19 the course was delivered in dual mode to accommodate a few students). The chapter is written by two early career health promotion academics, each with multiple years of experience teaching health promotion, alongside two health promotion students who are now also our postgraduate students
Which theories and methodologies are used in the teaching-learning process?	The course we draw on for this chapter is informed by critical, relational and dialogue pedagogies, as well as underpinned by health promotion values. The key emphasis in the course, particularly strengthened at the beginning of the semester, is relationship building with and amongst students. We draw on a pedagogical approach that enables students to bring their experiences to the classroom, feel a sense of belonging and connect with health promotion concepts. Students learn about the value of relationship and dialogue for their learning. Critical pedagogy is also embedded within the course through the inclusion of justice, power and intersectional lenses and solidified through entries into a critical reflection journal

(continued)

Table 15.1 (continued)

Questions	Take-home messages
What kinds of forms of assessment are applied, results achieved and challenges faced?	The assessment is outlined in detail in the chapter but is of course interwoven with the applied pedagogy. The wiki assessment was valuable beyond the relational and collaborative aspects in strengthening, enabling and supporting student engagement, writing skills and the ability to draw on their wiki content throughout, as well as after, the course. Through the easy user interface and diverse media, the wiki tool enables students to develop digital skills with minimal challenges. Through its accessibility via browser, smartphone or tablet, it further enabled students with different devices to engage easily. Students engaged very well in the course and achieved for the most part very good grades, and importantly were engaged in the course content across the semester
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	We base our teaching and learning on the IUHPE and Aotearoa New Zealand health promotion competencies, which guides content selection and foundations to teach across the health promotion curriculum. We draw on relational, dialogue and critical pedagogy principles to engage and learn collaboratively with students. Additionally, we draw on our university's teaching and learning strategy, which takes a values-based approach situating those values around six Māori concepts (loosely including aspects such as relationships, care, reciprocity, independence in learning, leadership). Lastly, although inherent in the competencies and strategy just discussed, we also explicitly base our courses on a Treaty of Waitangi-informed approach that honours Māori as *tangata whenua* (people of the land in Aotearoa)
What others could learn with your experience? What is localised and what is 'generalisable'?	Our chapter includes aspects of pedagogy interwoven with an assessment tool that can be used within this pedagogy. The context-specific requirements include naturally a digital landscape that assumes access to digital technologies and the Internet. Although the class described has weekly in-person contact, this approach is also useful for distance only courses. The nature of small communities throughout the semester can support students with many different backgrounds. Increasing the awareness and use of relational pedagogy in health promotion appear also generalisable due to the inherent human nature and requirement in health promotion to connect with people. On the whole the approaches discussed within this chapter are fairly flexible and could be adapted to a range of different contexts and learning

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Chapter 16
Innovative Pedagogies in a Health Promotion Specialisation: Knowledge, Practice and Research

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Introduction

Health promotion involves working towards an equitable distribution of health through social transformation (Marmot, 2005). We argue that to achieve this requires the careful development of a health promotion education that acknowledges that education itself should be transformational through student-centred learning activities related to theory, practice and the integration of the two. According to Fink (2013), education should involve 'significant learning' which involves transformation of students at various levels, from subject knowledge to learning about oneself and others. This chapter addresses the endeavour of using innovative pedagogies within and across modules, to facilitate health promotion education at master's level across three modules specialising students in health promotion: foundations of health promotion for development, an internship module relevant for health promotion practice and writing a 30-credit master's thesis on a health promotion topic. In the chapter, we address the challenge related to structuring and developing teaching and activities in the three modules such that each of the modules builds on and complements each other, and such that we, after the three modules, graduate health promotion specialists.

As we share our experiences with this work, we draw on two student case examples – one illustrating a clear direction towards health promotion *practice* and one illustrating a clear direction towards health promotion *research*.

Context

This chapter is based on experiences from a master's level programme at the Department of Health Promotion and Development, Faculty of Psychology, University of Bergen, Norway. The programme is called Global Development Theory and Practice, and students choose to specialise in either health promotion or gender studies (GLODE, 2021). We admit a new cohort of between 20 and 30 students every year for 1 year of taught modules followed by a second year of thesis writing (or students may choose to do an internship plus a short thesis). We accept both Norwegian and international students, and we have between 10 and 15 nationalities per cohort, with students coming from Asia, Africa and Latin America as well as North America and Europe. As mentioned, the programme has two specialisations (health promotion and gender), and we admit students with a bachelor's degree in a broad range of social and health sciences related to these two specialisations. We have an interdisciplinary staff with backgrounds in health promotion, geography, development studies, psychology and social anthropology.

In this chapter, we describe three modules: a 10-ECT (6-week) foundation of health promotion module named 'Foundations of Health Promotion for Development' (GLODE306, 2021); a 3-month, full-time (37.5 hours/week) internship (30 ECTs)

(GLODE310, 2021); and a 30-ECT thesis written over 4 months (GLODE330, 2021). The foundations of health promotion module involve approximately 6–8 hours of classroom-based teaching and learning activities per week in addition to self-directed learning. The thesis module involves three 5-hour workshops (approximately once a month) and self-directed learning plus regular supervision. The master's programme was run for the first time starting in August 2016. Since then, the three modules outlined in this chapter have been run for each new class, taught annually, and a total of five times.

The overall objective of this chapter is to show how implementing a variety of student-active learning activities across several modules can facilitate students' development of health promotion core competencies and prepare them for careers in health promotion research and/or practice.

Theories and Methodologies Used in the Teaching-Learning Process

In our study programme, we have a student-centred and student-active teaching and learning philosophy. This implies that we strive to develop and carry out our teaching with the aim that students acquire higher-order thinking skills that have transformational potential as according to Biggs' taxonomy of different types of learning (Biggs, 1996). We do this through using a range of student-active teaching and learning activities which are grounded in theoretical knowledge about what supports students' deep learning. Whereas traditional teaching approaches give emphasis mostly to transmission of *content* and that resulting in *passing* (an exam) – declarative knowledge – Biggs (1996) argues for a stronger emphasis on *process*, which is facilitating for students working actively, motivated and engaged with tasks to achieve deeper understanding of concepts. This will result in procedural knowledge (skills necessary to apply the knowledge) and conditional knowledge (awareness of when/where to apply). Biggs (1996) advocates for different types of learning approaches to achieve this, among others problem-based learning (PBL), which we in our programme rely on in several modules (see also the Chap. 11 by Daniel and Urke in this volume). Walsh (2007) contextualises Biggs' (1996) ideas in the work-based learning field through the emphasis of active involvement and 'doing'. This is relevant for our programme, specifically related to the internship module.

Fink (2013) presents a 'Taxonomy of significant learning experiences' which includes domains for potential learning and development in students when the education is structured with the aim of transformation of students. The domains include foundational knowledge; application of knowledge; integration of knowledge; learning how to learn; caring about a subject; and lastly a human dimension, involving learning about oneself and others.

This taxonomy can be helpful for guiding the focus of teaching and learning activities within and across modules to facilitate deep and significant learning towards health promotion specialisation.

Innovative Learning Methods

Students' learning outcomes are determined not by what we as instructors do but by what students do (Biggs, 1996). What is key is how we as instructors facilitate students' engagement within and across our modules. What we want them to learn, as stated in module learning outcomes, must therefore also be reflected in the teaching and learning activities we have students engage in. In this section, we will describe and discuss central learning activities we make use of in our modules from a pedagogical and theoretical perspective.

Problem-Based Learning (PBL)

PBL is a student-centred learning activity in a collaborative and authentic setting where students work to solve real-world and subject-relevant cases (Yew & Goh, 2016). Typically, students work in groups of four to six members over some period. In our modules, we tend to have students work on a specific case for 3–4 weeks that ends with a presentation. The PBL process should follow specific steps to ensure thorough learning and that all group members are given the chance to contribute. In Fig. 16.1, you see the 'PBL wheel' which includes the steps that the group is to follow. In GLODE, we always encourage each PBL group to choose a chair and secretary for each session the group has. The chair's main responsibilities are to monitor where the group is in the process, make sure there is sufficient progress and facilitate for all members to contribute (e.g. by initiating 'a round' giving each member time to present ideas and opinions).

According to Dolmans et al. (2005), PBL has its foundation in central principles of learning, namely, that learning should be *constructive*, *self-directed*, *collaborative* and *contextual.* When students take active part in their own learning, they connect previous and new knowledge and construct or reconstruct their own knowledge (Dolmans et al., 2005). When learning is self-directed, students are actively involved in the whole process of the task, from planning to monitoring and evaluating the learning (Ertmer & Newby, 1996). In PBL, students are responsible for setting their own objectives, assessing what knowledge and competence exist in the group and identifying learning needs. Together, students plan what needs to be done, and monitor whether they are on the right track to achieving their objectives within the time at hand. Further, evaluation of own and group processes is central, both after each meeting and at the end of the PBL period. Learning as a collaborative process involves two or more people having a common learning goal, sharing responsibility

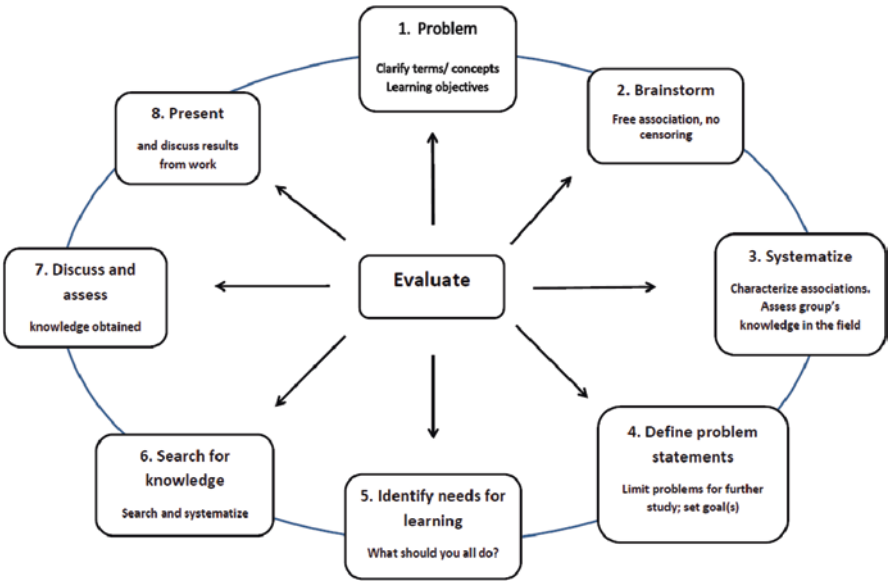

Fig. 16.1 The 'PBL wheel' used in GLODE

and being mutually dependent on each other to achieve that goal (Dolmans et al., 2005). The PBL process requires integration and reconstruction of members' knowledge, not just simple division and presentation of individual tasks. When students engage with each other in the PBL setting, it facilitates deeper learning through elaborations, critical discussions and reconstruction of knowledge. Lastly, learning is contextual, and facilitating the transfer of knowledge across contexts can be challenging. PBL can facilitate viewing subjects from various perspectives and considering multiple approaches to solving tasks. This process can in turn be beneficial for students' future application of the knowledge acquired (Dolmans et al., 2005).

PBL is not a 'magic bullet', but when implemented according to its intention, it can facilitate the various learning processes outlined above. When students are presented with open and realistic problems or cases, with active, but not dominant, tutors, and have an open, evaluating and reflecting approach to the group work, PBL can indeed contribute to higher-order learning (Dolmans et al., 2005).

Professional Practice Through Internship

Internships as part of higher education have become increasingly popular to bridge the gap between theoretical education and professional work life (Nghia & Duyen, 2019). Specifically, internships are valuable opportunities for students to apply the theoretical knowledge and skills they have acquired through their education, in authentic settings (Nghia & Duyen, 2019). In addition to increased employability,

better salary and higher job satisfaction (Gault et al., 2000), research indicates several other benefits from taking on an internship as part of higher education, including high levels of active learning (Gilbert et al., 2014), enhancement of oral and written communication skills (Knemeyer & Murphy, 2002; Scholz et al., 2004) and ability to work independently (Scholz et al., 2004).

These aspects talk in favour of incorporating internships as part of an innovative pedagogy in higher education, but it is not enough just to offer an internship opportunity. It is likely that certain factors are important for a successful internship in terms of students' academic and professional development (Narayanan et al., 2010). Exploratory research indicates that student choice and knowledge of the internship can positively influence internship progress (Narayanan et al., 2010). Further, research suggests that students that find their university studies helpful for the internship also report higher learning in the internship, which in turn is positively associated with student internship satisfaction (Narayanan et al., 2010). Finally, being able to have a say in the choice of internship advisor or mentor seems to be positively associated with student internship satisfaction (Narayanan et al., 2010). The research of successful internships indicates that the incorporation of an internship module requires careful module design following Biggs' (1996) principles of constructive alignment where students actively construct their own learning through meaningful interactions with previous modules (see also chapter by Daniel and Urke in this volume on alignment across modules) where tasks in the internship can be connected with existing knowledge gained in their higher education.

Oral Presentation with Peer Feedback

Communication (oral and written) is considered a key professional competence to be acquired in higher education across several disciplines and fields (Dunbar et al., 2006; Joint Quality Initiative, 2004), including in health promotion (Barry et al., 2012). Further, it is argued that oral presentation skills are particularly valuable for professional and academic work life (Dunbar et al., 2006; Živković, 2014). According to Živković (2014), students need multiple opportunities to practise their oral presentation skills, and the practice should be guided (van Ginkel et al., 2015). Becoming comfortable with presenting orally is important for future professional life, but it is also a way of learning as it facilitates students' full participation in their interaction with the subject they are studying. When students are required to give an oral presentation on a topic, it forces them to reflect on what they know (and do not know), select what and how to communicate. An oral presentation can perhaps be thought of as a type of active recitation of a specific topic/subject, which is claimed to be a highly effective way of learning.

Peer feedback is praised as a learning activity as evidence indicates that it facilitates development of metacognitive skills and self-reflection (Nicol et al., 2014) both for the provider and receiver of the feedback. When students read other students' work, they read it through the lens of their own work. Hence, the process of

producing peer feedback provides space and opportunity for the improvement of one's own work as well. Cowan (2010) points to the skill of making evaluative judgements as a crucial professional skill as it promotes higher-level cognitive abilities. One way of facilitating this skill is through giving quality peer feedback. This further supports the use of peer feedback in higher education, including in our programme.

Three Modules in the Health Promotion Specialisation

The specialisation in health promotion in the GLODE programme comprises the three modules as described above, and the aim is '…to give the student expertise in health promotion theory and practice in the context of global development' (GLODE, 2021). In this section, we detail the three modules using the three dimensions of Biggs' (1996) 'constructive alignment' concept: learning outcomes, teaching and learning methods and assessment forms.

Foundations of Health Promotion

'The objective of this Module is to explore the foundations of health promotion theory, practice and research, originating in the WHO Ottawa Charter for Health Promotion related to Development' (GLODE306, 2021). In formulating our learning outcomes, we have relied heavily on the core competencies of health promotion (Barry et al., 2012), especially for the *knowledge outcomes* which we modified only (i) by adding 'as related to development' and (ii) by grouping theories into 'families' of related conceptual frameworks (see Box 16.1 on Health Promotion Learning Outcomes: Knowledge, and compare with Barry et al. (2012, p. 21) where they list the knowledge base underpinning health promotion core competencies).

We use a variety of teaching and learning methods including lectures, PBL, workshops and colloquiums. We use lectures to present threshold concepts, principles and theories. Lectures are always followed by either a workshop or colloquium so that students apply and engage with the concepts, principles and theories themselves. We use PBL problems for students to engage with development-related health promotion such as climate change and health implications, or health promotion among refugee populations. In assessment, a single grade cannot be awarded based on both group and individual works, so we make participation in the group work obligatory in order for students to be allowed to take the home exam which is graded.

Box 16.1 Health Promotion Learning Outcomes: Knowledge

- The concepts, principles and ethical values of health promotion as defined by the Ottawa Charter for Health Promotion (WHO, 1986) and subsequent charters and declarations
- The concepts of health equity, social justice and health as a human right as the basis for health promotion action related to development
- The family of socio-ecological theories such as determinants of health and their implications for health promotion action related to development
- The family of strengths-based theories such as salutogenesis and their implications for health promotion action related to development
- Emerging theories applying health promotion principles in a development context
- The impact of social and cultural diversity on health and health inequities and the implications for health promotion action
- The systems, policies and legislation which impact on health and their relevance for health promotion

Results Achieved and Challenges Faced

In evaluations students report appreciating the concept of lecture-workshop pairs where theoretical concepts are addressed in the lecture and more actively applied in the workshop. Similarly, students have expressed that the PBL case gives an opportunity for them to apply core health promotion theoretical concepts to real-world health issues. However, student evaluations have also indicated that the module is too short and intense to effectively include PBL. This shows that although PBL can be a fruitful way of learning, it needs to be carefully adjusted to the conditions of the modules, taking into account aspects like the length of the module in relation to the scope of the PBL case. Although PBL involves a specific process and work methodology, it is possible to adopt PBL principles and ways of working into other group activities, like colloquiums, etc. As instructors we are attentive to students' feedback and continuously consider alternative ways of supporting learning through various forms of student-centred activities.

Internship

During the internship, the student works full-time for 3 months at a public or private sector organisation or NGO – or, in fact, a research institution. The objective of this module is for the student to 'experience, develop understanding of, and reflect critically on professional/academic practice, through participation in the daily operations of a development/government/research organisation' (GLODE310, 2021). In

general, students find and arrange the internship themselves, with supervision and support from programme staff where necessary.

Learning outcomes: As each internship takes place at a different organisation, *knowledge* outcomes are general (e.g. knowledge of professional etiquette and culture). *Skills and competence outcomes* are more substantial and include, for example:

- Set one's own learning outcomes, to be mastered through the internship.
- Apply academic knowledge in a professional setting to solve real-world problems.
- Set professional development goals in collaboration with superiors.
- Evaluate one's own performance and set improvement goals.
- Give constructive feedback to colleagues on one's work experience.
- Relate effectively to persons on different levels in an organisation's structure.
- Communicate within and outside a professional organisation in a manner in keeping with the organisation's mission and values.
- The ability to enhance one's own professional competency based on reflection over self-assessed and mentor-assessed performance.
- The ability to be a good team player.

Teaching and learning methods are largely centred on the student, although we do run two workshops in the semester before the internship to work on how to systematically and carefully read organisation websites, write high-quality application letters and produce comprehensive CVs. During the internships, students learn through hands-on experience working in a professional setting. Assessment is through a (short) report from the organisation and a 20-page written report by the student focussing on methods and activities used to master the self-established objectives, the results achieved and critical reflection about the experience. As the organisation may not have an explicit focus on health promotion, students are also asked to critically reflect on how their experience during the internship relates to all they have learned during the programme's taught courses, especially their health promotion specialisation.

Results Achieved and Challenges Faced

Throughout the period we have offered students internships, we have had 100% completion rate. Student evaluations are generally positive with students appreciating the work and professional experience they acquire. Several students have been offered paid positions in their internship organisation upon completion of their internship and/or master's degree.

Challenges have also come up, including students experiencing too little preparation guidance in the early process of finding and applying for internship positions, lack of follow-up by their internship supervisors and too heavy workload in their internship. We have addressed these challenges by introducing the preparation workshops described above and by having monthly physical or digital meetings between the student and their university supervisor to pick up and be able to assist the students with challenging aspects of their internships.

Master's Thesis (GLODE330)

The master's thesis gives students the opportunity to demonstrate their ability to work independently, plan a research project, apply knowledge and skills learned in the first year to collect and/or analyse data and write up and discuss the implications of their findings on a development-related health promotion issue.

Learning outcomes include *knowledge* on the significance of objectives and research questions, how to conduct a literature review and how to use an appropriate theory to frame the project. *Skills and general competence* include the ability to plan and conduct an independent research project under supervision and in accordance with applicable norms for research ethics, in addition to analytical and reporting skills. Students also have the ability to communicate their own research extensively and to assess that of others.

Teaching and learning methods are largely self-directed by the student although students are required to participate in group supervision meetings, to present a chapter of their thesis work and to peer review other students' work. The 40–50-page master's thesis is the way the module is assessed.

Results Achieved and Challenges Faced

The incorporation of master seminars in the writing process is evaluated as a positive element by students as it facilitates regular contact with the rest of the student group in what can otherwise be experienced as a lonely process. Students also express that the presentations they have to prepare put additional pressure on them to work continuously with their thesis as they have to present to a wider audience than their supervisor.

A challenge with the one semester thesis is the relatively short period that students have at their disposal for writing the thesis. Students writing theses based on qualitative data are expected to complete data collection before the semester of the thesis writing starts. This is sometimes not possible which delays the students and influences what they have to present in the seminars early in the semester, reducing the usefulness of these seminars. To address this challenge, we emphasise the importance of good quality in the preparation process with writing a feasible project proposal, starting early with the ethical clearance process and data collection.

Description of Two Student Examples

In the following we describe two student cases, both following the three described modules, but with slightly different focus in their internships. The two cases are here meant to illustrate the outcome of the innovative learning methods within and across modules in our programme. More specifically, we aim to show *how our*

programme facilitates for students developing as health promotion professionals with innovative learning methods.

Case One: Health Promotion Research Focused

This example presents the three modules in light of an internship in a research organisation.

Upon completion of the foundations module, this student was offered an internship at a Norwegian research institution. The connection with the institution came about by a GLODE staff member based on the expressed interests of the student.

The main role of the student in the research institute was as a research assistant on a research project in the start-up phase. Work tasks included mapping climate protest movements in Oslo and working together with the rest of the research group to explore some of these movements more in depth, and developing interview guides for data collection. Another main task was organising a panel debate for a conference, also on the topic of the mentioned research project.

Based on the internship, the student developed her thesis topic and was in a position to more easily access participants for data collection.

Case Two: Health Promotion Practice Focused

This example presents the three modules in light of an internship in an NGO working with an indigenous community.

Upon completion of the *foundations* module, this student purposely sought out an internship both within a field of her interest and in a geographic region of her passion: an NGO in a Latin American country working for and together with indigenous women to promote health and life quality. The project the student was mostly involved in was an integrated health initiative for women and their children. The internship tasks included planning activities and workshops and developing competencies for upcoming workshops in the integrated health programme. She also contributed work in other programmes of the organisation and was active in the day-to-day running of the organisation. One major task and responsibility that she was trusted with was developing an evaluation plan for the integrated health programme.

The student wrote her master's thesis on the topic of indigenous women's perspectives on health in the area of and in cooperation with the internship organisation. The connection with the organisation facilitated access to participants, and also increased the student's knowledge about the area in terms of current and previous cultural and social situations.

Discussion

In the following, we discuss how the learning activities we include in our modules contribute to the development of health promotion core competencies (Barry et al., 2012) and how the modules build on each other to achieve deep and transformational learning in students preparing them for the health promotion profession.

The Core Competencies Framework for Health, or CompHP (Barry et al., 2012), includes nine domains of expertise that health promotion professionals should possess: enable change; advocate for health; mediate through partnership; communication; leadership; assessment; planning; implementation; and evaluation and research. These competencies are underpinned by a commitment to ethical values and principles of health promotion and a strong health promotion knowledge base (Barry et al., 2012).

We have specifically designed our modules according to the CompHP framework, striving to ensure that all of these domains and underpinnings are covered to some extent, to make sure that a specialisation in health promotion at the GLODE programme aligns with this commonly agreed standard of health promotion competency.

Health Promotion Competencies as Outcome of Learning Activities in Our Modules

As can be seen from the description of the foundations module, the learning outcomes are almost the exact formulations as the *knowledge* underpinnings in the CompHP framework. This guides the content covered in our teaching activities like lectures, workshops and PBL cases. Further, through the range of our learning activities across the three modules, we aim to facilitate for the development of the nine competencies mentioned above.

Leadership

In the PBL in the foundations module, students have to take turn on chairing the group. This gives valuable practice in taking leadership responsibility for group processes, including planning, monitoring and evaluation. The diversity of our student groups in terms of disciplinary background, gender and nationalities further enriches the leadership experience. This practice in leading groups also shows to be very beneficial for students entering internships, as they report being more comfortable with contributing to collaborative group processes in their internships. Further,

the internships often give them even more experience in leadership through having main responsibilities for parts of or even entire projects.

> Perhaps the most extensive and also most challenging task I was given was to create an evaluation plan for the Integral health program. (Student report 2)

Communication

As the closure of the PBL process, the groups give a presentation where all group members contribute, and this is valuable practice in oral presentation skills – as discussed above, an important aspect of communication competency (Dunbar et al., 2006). Through internships, many gain additional experience with several forms of communication, including written reports and oral and written presentations. Both student cases in this chapter had tasks that involved communication of one or several forms, here exemplified by student in Case 2:

> I spent the afternoon selling pies to the Spanish School I had previously been attending. This was a great chance for me to practice the way I represented the organization, as well as talk to other people about our mission in the community. (Student report 2)

In the thesis writing module, students are further trained in communication skills, naturally through the writing of their thesis, but students are also required to give an oral presentation of selected parts of their thesis to their peers. This requires them to synthesise the content of their thesis work, and rework it into a format that fits the oral presentation genre. They also have to take care to communicate a familiar topic to an audience for which the topic and methodological approach may be unfamiliar. Explaining a subject to peers is a recommended way for increasing one's own deep understanding of a subject.

Further, as all students are required to be the main commentator for at least one student presentation, they are also trained in giving oral feedback which is a valuable communication skill both in and outside of academia. Additionally, and most relevant for the health promotion specialisation, students practise these skills in the context of health promotion topics, which further strengthens their specific health promotion communication skills.

Enable Change, Advocate for Health and Mediate Through Partnerships

The theoretical and knowledge underpinnings taught in the foundations module create the basis for understanding what enabling change, advocating for health and mediating through partnerships might involve – at least in theory. Through lectures,

PBL and workshops, students address health issues, global and local, through the framings of these three core approaches of health promotion. Further, as they move into their internships, the aim is that they reconnect with this knowledge, apply it to new problems and integrate ideas in new contexts (Fink, 2013), e.g. in their internship tasks:

> My eyes slowly began to open up for how theory of development links to practice of development. I enjoyed going back to old lecture notes as well as to previous projects and evaluation plans we had been creating earlier in the GLODE program. (Student 2 report)

Assessment, Planning, Implementation and Evaluation and Research

In the PBL tasks, we aim to cover several of the CompHP competencies, and although not all competencies are covered in each PBL assignment, students do become familiar with them during the course of the full GLODE programme (see Daniel & Urke in this volume). For example, a PBL assignment can involve making a plan for the assessment of a health issue at individual or community level, and/or plan measures addressing this health issue, e.g. through approaches of enabling change, advocating for health and/or mediating through partnerships. This is at a theoretical level, and in our *practice module* (see Daniel & Urke in this volume), students get more experience with actual planning and/or evaluation work for organisations. The internship module is probably the module that best facilitates the development of the *implementation* and *evaluation* competencies, when students, depending on their internship tasks, gain first-hand practical experience with putting plans into practice and/or evaluating initiatives. The student who had internship in the women's organisation was, for example, involved in implementation of health programmes, and in addition was asked to develop an evaluation plan for the same programme. In her internship report, she stated the value of going back to literature from previous GLODE modules to find evaluation frameworks and theory that could guide her in this work.

For the student in the research organisation, the work she was assigned was related to research in a field of her interest, and in the end this work inspired her thesis topic quite specifically. Her main role in the internship was as a research assistant, and the organisation gave her substantial responsibility for parts of a research project. According to her own reflections, this provided her with valuable research experience relevant for writing her own thesis:

> I am more than capable of conducting my own research project, and I feel like I know more or less how to plan and carry it out after being a part of the (name of project) team. (Student 1 report)

In line with Fink's (2013) concept of significant learning, this shows how the internship as an innovative learning activity shaped learning and contributed to valuable *research* competency even before starting her master's thesis work.

Integration of Knowledge, Skills and Competencies Across Modules

Reflecting on the GLODE specialisation in health promotion in three modules, we would argue that through our innovative learning activities, we facilitate for the development of health promotion competencies in our students, and we also facilitate for transformational learning in line with Fink's (2013) taxonomy of significant learning experiences. Foundational knowledge in health promotion is ensured through following the CompHP knowledge underpinnings. Students apply this knowledge through critical, creative and practical thinking about health issues in, for example, the PBL setting in the foundations module, hopefully achieving the *application* learning experience (Fink, 2013). In the foundations module, students engage in PBL to solve authentic challenges/cases acting as 'expert groups', etc. They practise leadership skills and communication skills (and more) in safe environments. We further aim for students to develop academically and professionally by connecting new knowledge to previous knowledge, and transferring knowledge, skills and competencies to new contexts and situations. As shown with references from the internship reports, internships have prompted the integration of health promotion knowledge to other contexts – another significant learning experience (Fink, 2013) – and made students connect ideas across health and development issues and practice fields:

> Having an internship is a great way to take what you learn in lectures and seminars and apply it to real life situations. I believe it is of high value for students because it is a more active way of learning. (Student 1 report)

Additionally, in their internships, several students have experienced engaging in professional collaboration where their previous practices of leadership and communication skills have come to use in real-life settings.

Fink (2013) calls for learning to be transformational also when it comes to how we see ourselves and others. In the learning activities of PBL, the internship and thesis presentation seminars, students may come to see themselves and others from new perspectives and understand each other better as they collaborate and accomplish learning goals together and individually. Further, going deep into a subject – be it a PBL problem, a new cultural context, a new workplace (internship) or a thesis topic – nurtures interests which develop new feelings and values, creating professionals who care (Fink, 2013). These experiences, we argue, are qualitatively different from the traditional lecturing as learning activity, and together lead to reflective self-directed students who are ready to take on the tasks of future health promotion research and practice.

Localised or Generalisable

Building on Biggs' (1996) model for constructive alignment, Fink (2013) argues that successful designing of integrated courses with connections between learning goals, teaching activities and feedback/assessment requires also careful consideration of situational factors. These relate to the specific and general teaching/learning context, what subject is taught (theoretical/practical), student characteristics and teacher characteristics. The approach to specialisation in health promotion described and discussed in this chapter is developed within the frame of these situational factors. We do not have very large batches of students, which enables close follow-up of student-active learning activities like PBL, and supervision of internships and thesis writing.

Health promotion is a subject that is both theoretical and practical, but the connections between theory and practice are not always made explicit. The combination of the foundations and thesis modules (which are mostly theoretical) and the internship module (practical) enriches the specialisation in health promotion. Whether this is possible for other programmes elsewhere will likely not depend so much on the nature of the subject but rather on general institutional policies and resources.

Our students come from a range of different countries and backgrounds. This provides a rich diversity to our programme and to the teaching and learning experiences of staff and students. The many perspectives that we encourage and meet provide our students with a broader and deeper understanding of the role of context for health promotion initiatives, and we believe this prepares them in a unique way for their internships and later professional life.

Conclusion

In this chapter we have described and discussed our experience with developing and running a health promotion specialisation at master's level. We argue that our programme achieves transformational learning and acquisition of core health promotion competencies through a strong emphasis on student-centred learning activities and close connections between theory and practice.

Table 16.1 brings our reflection on the six triggering questions suggested by the editors.

Table 16.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion should be applicable in all regions of the world – context will shape its form and processes
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	This is a master's level course, and participants include those with a broad range of social science backgrounds or with work experience in health and care services, civil society and public sector. Participants come from 6 to 10 different countries from the Global North and Global South (out of a total of between 10 and 20 students per cohort) We describe three courses here: a 10-ECT (6-week) foundation of health promotion course; a 3-month, full-time (37.5 hours/week) internship (30 ECTs); and a 30-ECT thesis written over 4 months. The foundations of health promotion course involves approximately 6–8 hours of classroom-based teaching and learning activities per week in addition to self-directed learning. The thesis course involves one 5-hour workshop a month and self-directed learning plus regular supervision. All courses are taught annually
Which theories and methodologies are used in the teaching-learning process?	Biggs' constructive alignment, Biggs' taxonomy, Fink's taxonomy
What kinds of forms of assessment are applied, results achieved and challenges faced?	The foundations course includes participatory learning methods such as problem-based learning (PBL) or colloquium workshops which are assessed through presentations and verbal feedback. All three courses include some form of written assessment (home exam, self-evaluative and reflective report and a 50-page thesis, respectively). The supervisor at the internship organisation writes a report assessing the student's contribution; and the thesis is evaluated by a committee Results: students have solid foundational knowledge of health promotion which they are able to apply both in practice, through the internship, and in research, through their thesis Challenges: some students experience internships as undemanding, while others are overwhelmed by the demands made on them
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	Every aspect of the knowledge base as well as most of the ethical values underpinning health promotion core competencies is taught. Students will apply different competencies depending on the requirements of their internships; all students use the research competency in their thesis
What others could learn with your experience? What is localised and what is 'generalisable'?	Student-active learning methods and the process of an internship could be applied anywhere, but the presence (or absence) of organisations will influence what type of internships is possible. Thesis research will be appropriate to the region

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Chapter 17
Health Educators *Love* Reading: Introducing the Journal Club for Lifelong Learning

Patrizia Garista and Giancarlo Pocetta

Contents

Introduction

This paper presents theoretical issues regarding the importance of information literacy as a tool for health promotion research, training, and practice and demonstrates that the journal club is a suitable teaching strategy for higher education courses and professional development.

Starting from the term "literacy," and the increasing need for literacy promotion among low-skilled adults, there are interesting findings that could be applicable for information literacy among academics and professionals (Virkus, 2003). Virkus outlines that poor literacy is not easily admitted to by the general public, and the

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consequential risk is that it remains invisible. Considering our experience as trainers and teachers, this phenomenon may regard health educators as their professional literacy on health promotion issues and information literacy skills. Good reviews nourish best practices.

Due to the knowledge-based society we live in today, information and media literacy skills are the basis for professional development to explore new scripts of action in complex and evolving situations. It has now been globally accepted that the incessant increase in the availability of information, which characterizes today's society, has placed emphasis on the importance of lifelong learning and the need for continuous professional development. Together with evidence-based practice, now a consolidated paradigm when aiming for quality and effectiveness in research, lifelong learning and continuous professional development call for *capabilities for selecting relevant and discarding irrelevant information, recognizing patterns in information, interpreting and decoding information as well as learning new and forgetting old skills* (OECD, 1996). In other words, be information literate.

In the case of higher education and professionalization, the problem is "intellectual risk-taking" (Montuori, 2005). Firstly, the promotion of critical reading skills is important for the comprehension of a text, whether scientific, literary, or informative; secondly, it also promotes a sense of professional growth in terms of lifelong learning in order to support health professionals as reflective and critical readers. If basic literacy skills (Freire & Macedo, 1987) are a prerequisite for higher education access, information literacy skills are a part of the professionalization process in higher and continuing education. Critical reading is a meta-cognition skill that is very important for an evidence-based health education practice. Moreover, critical reading is useful to explore new scripts of action in everyday health education practice just as reading for pleasure does in everyday life (Wooden, 2011; Garista et al., 2015). At higher education levels, such skills are mastered through reviewing literature.

A New Context for an Old Learning Methodology

The Master's degree "Planning, Coordination, and Evaluation of Integrated Interventions in Health Promotion and Education" is a post-graduate continuous professional development course organized by the Research Centre for Health Promotion and Education within the Department of Medicine in Perugia (Italy). This course has been active within the European scenario since 1998, and it is conducted on a yearly basis. It is open to students who either possess a Bachelor's degree or have extensive proven experience in health education and/or promotion. As a consequence, the academic and professional backgrounds of participants vary considerably as do their aims and objectives for participating in the course. The Master's aims to provide the participants with the fundamental knowledge, skills, and abilities needed to provide high-quality evidence-based health education and promotion interventions (Tsouros et al., 1998).

The program of studies is divided into seven 1-week modules spread over a calendar year. The first two modules focus on the theories and models underpinning health promotion practice. Four core modules focus each on one of the phases identified in project planning models for health promotion suggested in literature, namely, needs/assets assessment, planning, implementation, and evaluation. Module 6 focuses on leadership and communication. The whole course is characterized by a spectrum of targeted socio-constructive activities ranging from role play and case studies to play-dough modelling and photo-elicitation as well as the journal club being presented in this article. The assessment is based on a final research thesis which must be completed by the next calendar year.

The course program is grounded in health education and promotion principles and values. Furthermore, latest developments in course standardization across the EU and the identification of core competencies for the accreditation of health promotion training and practice within Europe have added validity to the course format (Barry et al., 2012). In the last decades, the European Masters in Health Promotion (EUMAHP) consortium established a common track which is similarly organized; it starts from theory acquisition and moves on to needs assessment and evaluation (Foundations of Health Promotion (double module), Research Basics in Health Promotion, Health Promotion Practice, European Dimension of Health Promotion (double module)) (Davies et al., 2000). All the 11 domains identified in the CompHP Core Competencies (Barry et al., 2012) are dealt with at varying depths, and, save some further improvements planned for future editions, the students can demonstrate the necessary knowledge, skills, and performance criteria identified in the CompHP standards (Garista et al., 2015).

Over the years, the course has been modified and restructured because of such developments, but also because of its internal ongoing evaluation and quality assessment. During a tutor staff meeting, it was noted that participants showed lack of competencies in finding, assessing, and gathering new knowledge. Moreover, when they approached the final step (preparing their thesis), tutors noticed that the task requested varied considerably among students, especially when conducting the literature review. In addition, participants themselves reported difficulties in conducting experimental thesis projects in their own professional context. They described the problem of sharing and discussing with their colleagues (who have multiple perspectives on health education: different theory models, ways of approaching research, experiences).

Based on these reflections, a project about scientific/information literacy as professional health education competence has been started. Students attending the Master's program come from different disciplines (medical, nursing, psychology, social work, pedagogy, economy, health visiting, pharmacy), different ages, and different work settings (health service, hospital, community) and have different ways of approaching the thesis task and in particular the literature review, wherein each project must be based on either "evidence" or "narrative" or both. An additional point to consider is that, during the recent years, a "theory-based" planning implementation was required to run a health education intervention effectively as stipulated in several guidelines on efficacy in health education planning dissemination.

The ideas behind the introduction of a journal club in the health promotion course emanate from the authors' narratives of their previous experience in the use of journal clubs in medicine graduate courses, and the idea of adopting this strategy in health promotion was attractive to all tutors and teachers. In describing how this strategy for active learning (Mezirow) has been introduced, we aim to present a participatory process to share and construct knowledge in professional practice inside and also outside the course where "people live, work, love, and play" (World Health Organization, 1986).

Theories and Methodologies for a Creative Information Literacy Promotion

The literature review is a necessary step in planning studies and programs because it provides evidence for decision-making and problem-solving in community action. It opens a window onto different genres of literature and disciplines which make up the complex field of health education (Maturana & Varela, 1992). In addition, it works as a real strategy for meaning making in multidisciplinary group work. Nevertheless, searching for documents, articles, books, and abstracts could become a very *boring process*. The intellectual risk taking (Montuori) is to skip the stage of selecting, reading, and summarizing relevant evidence and go directly to the drawing board to plan objectives and actions. Skipping this stage could be considered as a coping style to avoid what could be viewed as a tedious task of reviewing the literature. In addition, many professionals often attend post-graduate programs for their continuous professional development, and the lack of time becomes a critical element, as adults with multiple tasks and identities (job, family, care giving, study). Time for reviewing literature is perceived as a monotonous work, useful only during years dedicated to the Bachelor's degree or a responsibility for researchers. As argued by Montuori (2005), this is a consequence of the heritage of an educational approach which demands reproductive work, a list of "who says what," making the reviewing a mind-numbing process both to read and write it.

To get health practitioners closer to the process of reviewing literature, a first step is to reorganize the teaching strategy in order to show another side of this process, that is to say the salutogenic (Garista et al., 2019), participatory, and creative element in knowledge-building within a specific community and the pleasure of reading and criticizing an article together. The review should not simply be a reply to someone else's discourse. On the contrary, it should be a dialectic experience among scholars, teachers, students, and professionals which takes place in the interpretation of the literature and in the later dissemination of one's own work.

Goldman and Schmalz (Goldman & Schmalz, 2004) also emphasize a personal element in the interpretation of scientific literature on health education. They proposed and describe the *matrix method* for literature review in health promotion planning that we adopted as learning outcome to be achieved by participants. They suggest classifying data selected during the review in a matrix form in order to

facilitate their organization and interpretation (Garrard, 2011). They also suggest writing a *log book* which will trace the process of selecting and analyzing literature starting from one's own background and experience. In this perspective, the boring list of theories and evidences will be reinterpreted in a narrative-based perspective. The literature review becomes a reflective practice for learners.

In the field of medical education (Topf et al., 2017; Deenadayalan et al., 2008; Bounds & Boone, 2018; McGlacken-Byrne et al., 2020), for instance, there has been a long-standing attention to the implementation of reading skills even for the continuous professional development (Wooden, 2011). And in nursing education (Johnson, 2016) or in neurosciences, improved approaches to scientific literature have been implemented. We can see increasing interest toward literature reviews also in social work and recently in pedagogical background to educational research (Golde, 2007). These disciplines show a longer methodological tradition to develop and promote information literacy. Among several strategies, the journal club is one of the most popular in the field of medical and nursing education.

Literature on the use of journal clubs shows multiple styles of application. The journal clubs seem capable to embody the participatory and creative element of literature reviews for health promotion in a teaching and learning community. Selecting, reading, and discussing papers about health education in a multiprofessional group are a practical example of sharing and interpreting new knowledge, research, and projects in a health education community and simulating the real world of health promotion settings. It demands everyone's participation in presenting or discussing a paper, overcoming professional roles, level of experience, and age. The journal club enhances participation in debating about literature, making it less boring and more attractive. In the classic journal club, participation is guaranteed by the participants' interests and motivation. In a higher education course, the challenge is how to motivate and attract participants, even if journal club is part of the planned program and, therefore, mandatory. Summarizing, the introduction of the information literacy workshop and journal club is based on theoretical assumptions and considers evidence of success from other learning contexts. It blends information literacy with values of self-empowerment, self-directed learning, critical reading, and appreciation for knowledge-sharing required for lifelong learning and professional literacy and to guarantee high-quality project planning. It also promotes participation and is valued by course participants as a profitable experience.

The Journal Club Design in a Learning Setting

The matrix method for literature review (Goldman & Schmalz, 2004) and the journal club were introduced, and a design was set up to monitor and evaluate the introduction of this approach. The idea consisted first in the gradual institution of a workshop on literature review and, as a second stage, the adaptation of the classic journal club into a participatory learning tool created and implemented by a

learning/teaching community of health promoters. The general aim of the teaching project was to set up an organized session on information literacy in the course in order to support creative reading skills on literature review and participatory planning among students with different backgrounds.

In order to improve training for literature review, a learning design was implemented in two editions of a Master's program in Health promotion and education. The learning design based on literature review, journal club, and creative reviews is made up of the organization of a workshop on literature review (1 day, *n* hours = 7), the organization of a regular journal club in the normal activity of a Master's program (2 hours for 7 modules), that is, the evaluation of the project.

The higher education project was made of the following:

- A lecture on how to organize a literature review and its contribution to health promotion research and practice
- An individual task on specific tools and website on mesh terms and key words (thesaurus, PubMed, repositories, etc.)
- A groupwork for organizing all information selected in a matrix
- A journal club example performed by lecturers/tutors
- The presentation of guidelines for planning and managing a journal club
- A journal club in an attractive social setting led by participants during each residential week

The study was implemented in first two consecutive editions of the course. A 1-day workshop and a journal club session for each of the seven modules were presented. At the end of this first edition, the introductory workshop and the journal club were evaluated during the evaluation session, made up of general comments on the Master's experience and of group discussion on what could be implemented. The participatory evaluation provided the basis for the modifications adopted to the following edition of the course, which was consecutively evaluated to design a definite guide to the organization of the journal club. The number of course participants was 13 in the first edition and 18 in the second edition of the course, 31 in total. The professional background included medical doctors, nurses, dieticians, health visitors, and social workers.

A Special Setting: Bridging Knowledge with Fun, Cultural Heritage, and Traditional Food

Whereas the traditional classroom and the university library were the setting for the introductory workshop, the journal club took place in a local café in the heart of the historic center of Perugia, a medieval city in the center of Italy. The choice of this setting was based on theoretical assumptions stemming from competency

development theories, previously outlined, and principles of holistic development endorsed by supporters of Health Promoting Networks such as Health Promoting Universities, among others. The club was called "Il caffé della salute," the Health Café, owing its name to the fusion between the setting and the theme that brought together all those present. The idea successfully achieved its aim in creating a friendly appealing atmosphere, enticing the members to discuss the scientific papers proposed in an unformal situation, full of salutogenic resources: good food, cultural heritage, and comfortable seats. This alternative setting made it possible to foster the pleasure of reading among the participants more easily, developing critical reading skills necessary for information literacy, while sipping coffee and nibbling on good food. In addition, it offered those present a tangible experience of how unusual and neutral settings, already available within the community free of charge in each city throughout the world, can be set up easily for knowledge building and sharing. At the end of the journal club, participants had more time available to socialize and extend their discussion through a senso-biographic walking (Boero & Mason, 2021) back to university through the renaissance city streets for their next lecture.

Methods and Tools

The introductory one-day workshop on conducting literature reviews was introduced on the first day of the first module of the Master's since, as outlined by Frank (Frank, 2002), the act of reviewing literature is considered as the phase zero in project planning.

The workshop was based upon lectures, 2 hours in total (on creative review and evidence-based practice and the use of the principal search database). Group work, with briefing and debriefing, is the way forward for researching for data online and collecting them through the matrix method of Goldman and Schmalz. In the same stage, the first journal club was conducted by tutors, choosing articles about the principles of health education (thematic line of the first stage). The first journal club is also the time to introduce this methodology, explaining rules and opportunities and encouraging every participant to present an article in the following journal clubs, paying attention to the relevant themes of that stage (research methodology, health education strategy, evaluation, and so on.). Therefore, the first journal club could last up to 3 hours, but normally, it lasts 2 hours for the presentation and discussion of two articles. Every participant should communicate his intention to present and manage the journal club to his tutor and to the organizational team. Participants wishing to present an article were asked to request that their tutors book the session, preparing an abstract of the paper selected. Naturally, the tutors remain at the participants' disposal to provide their assistance, when necessary.

Evaluating the Journal Club Through Learners' Voices

An essential part of our experience was devoted to the assessment, on one hand of the personal student progress in information literacy and critical reading competencies and on the other to the evaluation of the most effective way of including journal club within the whole Master's program.

The leading strategy for the entire evaluation process was chosen to be in line with the theoretical and methodological principles of the Master's, according to Fetterman, the Empowerment Evaluation model (Fetterman et al., 1996; Fetterman, 2017). In this empowerment-centered approach, the actors of the evaluation (for us both the Master students and the teaching staff) democratically participate in all phases of the decision-making process regarding evaluation: the who, what, how, when, and finally how to use the results.

Based on this approach, the evaluation design was divided into two phases corresponding to two consecutive editions of the Master's, with the explicit purpose that the indications obtained from the first edition should serve to improve the second one and, finally, that indications emerged at the end of the process would inform future Master teaching-learning plans.

Following the empowerment evaluation approach, teachers and learners discussed and agreed on the expected results and achievement. The synthesis of the discussion is reported below. The comparison between the two phases of the evaluation process concerned the following thematic areas:

1. Whether and how the journal club has contributed to developing personal scientific literacy competencies
2. Communication and interaction between participants
3. How the journal club can be effectively placed in the training structure of the Master's course
4. Conditions and feasibility for using the journal club in the real working context
5. Proposals and suggestions for the improvement of the journal club in the Master's

The following tools were considered appropriate for data collection:

1. An open-ended questionnaire, self-administered in the two phases of the assessment
2. One-to-one and group tutorial meetings, where students had the opportunity to demonstrate their progress regarding competencies
3. The final thesis, in which the discussion aimed at highlighting the critical points produced by the application of the journal club in the real working world

The journal club experience involved 31 students with heterogeneous backgrounds and four members of the staff. The questionnaires collected were 28 (13 in the first and 15 in the second edition).

The questionnaire was compiled at the end of each edition of the journal club and before the thesis. A two-step data analysis was conducted at the end of the second survey.

Table 17.1 reports the results of the evaluation process. In the first column, the key areas are reported in the form of a question; the second and third columns highlight the main responses and changes between the first and second stages of the evaluation.

In the second step of the analysis, the "participants' voices" were summarized into four general themes:

1. *Personal/ professional achievements as perceived by the students*
   Mostly, learners improved the ability to reading critically a scientific article and presenting it to colleagues and the ability to implement the matrix method for reviewing effectively the international scientific production related to the issue of their professional interest. In addition, the contribution of participation in the journal club in reading and understanding a text in English was also clearly expressed.
2. *Relationships within the learning community*
   The journal club fostered cohesion and sense of sharing within the training group, overcoming the traditional roles hierarchy in training context. This result was also facilitated by carrying out the journal club in an informal place (coffee bar) outside the usual training setting.
3. *The impact of the new competencies on the workplace*
   The journal club was found to be helpful in developing awareness of the usefulness of literature review in the design of health promotion interventions. Many students have taken the initiative to offer journal club in their service or work group, including as an on-the-job training method. The journal club has also been proposed in contexts other than the healthcare setting, for example, in school settings. This allowed the students to identify opportunities and obstacles of integrating the journal club into their work contexts.
4. *The impact on the organization of the journal club in the Master's*
   The reflections conducted, by the whole Master's learning community, in the transition from the first to the second phase of the journal club identified elements for improving the journal club methodology, in particular:
   (a) The journal club must accompany the Master's throughout its course and not be concentrated in a single stage
   (b) Participation in the journal club must be part of the compulsory learning credits and not voluntary (as was beforehand).
   (c) Articles that will be discussed in the journal club must be made available to the group in advance.
   (d) The presentation of the articles must privilege critical discussion and not be oriented merely toward the formal style of the presentation.

Table 17.1 Learners' voices on journal club experience

Question item	Answers of the first edition	Answers of the second edition
How do you evaluate the health café inside the Master program for organization, topics, article communication and presentation?	Negative considerations: Missed journals, last-minute organization, request for a map to reach the coffee place, the greatest presence in your organization, must be better organized, cannot be voluntary, must first decide who should Positive considerations: interesting for spaces for discussion and reflection (also useful for group relationships)	Interesting beyond the Master's program Engaging, welcoming, therefore suitable in a master that also promotes health of the operators Interesting for the return in the workplace Moment of aggregation for the group Positive because it promotes critical reading skills People like the idea of non-institutional space because it brings students and teachers together Negative: There may also be a post-debate
How has the JC contributed to develop your scientific literacy?	Improvement of communication skills Exercise to translate an article from English Stimulus for bibliographic research It has opened windows of knowledge Learning development because the topics were chosen by the students Comparison with a reading model of a scientific article different from mine Opportunity to deepen the content of the article rather than teaching how to present an article It helps understand how to read an article It allows the sharing of updates	Biblio research was a novelty as a skill Being engaging, it stimulates learning It was a discussion on the critical reading of the articles Biblio search improvement Improved reading and presentation skills (2), etc. But not writing (3) Opportunity to do bibliographic research Opportunity to pay attention to reading Pleasant way of exchanging what international literature proposes
How does JC improve master topics learning?	Journal as a supplement to a lesson The best part is the discussion	Discussion sharing enhance learning Create a group atmosphere

(continued)

Table 17.1 (continued)

Question item	Answers of the first edition	Answers of the second edition
Do you have shifted the JC in your workplace?	Proposed in services, colleagues find it interesting because it is linked to the development of a project, proposed monthly Proposed in an epidemiology and statistics course as a final group work on data analysis Used during regional health education leaders' meetings: good feedback Proposal in a voluntary association Proposal in a small municipality with citizens (HL) Hypothesis of realization within a service Hypothesis of spreading it in one's own service	There is the idea of proposing to the ASL (Local Health service) working group Could be redone (3) Proposal to do so It made some unsuccessful attempts It could be an idea to be proposed to schools
If yes, can you describe how and which feedback you received?	Useful to discuss experiences in relation to the themes	
Do you have observations, proposal to a better development of JC?	Make a calendar and give people homework Don't ask to search for items but give them If there are no students, let the staff do it A place closer to the master setting is more convenient Participation outside the training context could be extended	The article could be delivered to the participants the day before

Conclusions

Innovations for increasing better professionalization in higher educations are a challenge. To control and evaluate these innovations, we decide to move toward an empowerment approach capable of underlining, as a case example, strengths and weakness of a traditional medical education activity in a new field: the journal club for health education. The story of the Health café shows that creative journal club enhances interest and motivation in reading routines and that health practitioners *love reading together.* Journal club, or in its Italian version "the Health Café," became a constant and always appreciated learning activity within the Master's program. We could add that its particular and informal setting made it possible even during pandemic time, by choosing a natural environment, a real alternative to overwhelming web proposals. Evaluation feedbacks from the first edition were crucial, so we suggest introducing this methodology and monitoring its impact. Journal clubs have been shown to be effective in learning, coherent with the most advanced statements regarding health promotion professional competencies, and appreciated

by teachers and students for their capacity to involve participants, stimulate their curiosity, and give them ideas to be implemented when they go back home. Journal clubs could be adapted to different topics: they are flexible and sustainable enough to be easily exported in singular learning contexts.

In conclusion, critical reading for developing a scientific literacy is a necessary skill to promote "critically" (and maybe more creatively) health literacy. The creative component induces the same pleasure that people feel for leisure reading. As a sort of well-being reading cycle, creative reading could affect scientific literacy as health literacy looking for pleasure in both literatures.

Even though if this experience is contextualized in a European country, it could be adapted in other countries. Journal club has a long and international history in medical education. The participatory, interdisciplinary, and creative components of our experience in a teaching and learning setting are also the principal guarantee for its reinterpretation and reproduction, following local traditions, cultural interests, environmental assets, and participants resources.

Table 17.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 17.2 Authors´ reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	In our vision, health promotion is an empowerment process where critical thinking and salutogenic thinking meet for creating quality of life and positive life paths. Health promotion and salutogenesis are embodied in people's everyday lives and in their stories. This vision embraces an ecological and systemic perspective that we summarize in the planetary health approach. For this reason, storytelling, reading, and writing in general are considered coherent and creative strategies to approach health promotion literacy development and to mobilize resources in learning and teaching within a scholar, a professional, or a lay community
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	The journal club case example described in the chapter has been developed within a Master's Program in Health Promotion in Italy, at the Experimental Centre for Health Promotion and Education-University of Perugia. The Experimental Centre has been always involved in international projects and in contact with IUHPE. As a consequence, it embraces all the principles and values of health promotion that it promotes and disseminates in several training proposals for health practitioners. Lecturers and researchers represent several disciplines, and its program is attractive for several professions from the medical sector but also social, educational, legislative, and political, or economical. Usually, practitioners who attend the Master's organize health promotion training for their colleagues in collaboration with the center, creating a bridge from research to the health sector and their communities

(continued)

Table 17.2 (continued)

Questions	Take-home messages
Which theories and methodologies are used in the teaching-learning process?	Theories used in the teaching process merge the medical education tradition on journal club with a constructivist paradigm in knowledge building. Participation, empowerment, and the idea of creating a salutogenic learning environment are the basis on which journal club has been revised in a more social and creative version, immersed in the historical and cultural environment of our country. We can affirm that the teaching strategy tries to simulate and integrate all dimensions of health through crucial health promotion strategies as empowerment, participation, and intersectionality
What kind of forms of assessment are applied, results achieved, and challenges faced?	The challenge posed to evaluators by the health promotion principles is really demanding in order to be as highly coherent as possible with them. In the experience we presented here, we faced this challenge adopting an empowerment-centered approach for the evaluation process in which all the actors involved, for us the Master students and the teaching staff, democratically participated in all phases of the decision-making process regarding evaluation: the who, what, how, when, and finally how to use the results. In our experience, the JC demonstrated to be effective as a method aimed at improving Master students' information literacy and their specific competencies of implementing a structured method of organizing and processing the review of the scientific literature on one hand and, on the other hand, at improving their ability to include JC in their working context
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The plan of teaching and learning through journal club addresses the implementation of information literacy, critical reading, and group working among health promotion practitioners. The general framework in which these skills could be included is the CompHP framework, which defines the key competencies for certificate health promotion practitioners. In addition, this experience could help health practitioners master this methodology for themselves and its possible implementation in informal groups of continuing education. And, finally, it could also be adapted, as some participant showed us, in a version addressed to a community, to face and debate health issues, implementing people health literacy
What could others learn with your experience? What is localized, and what is "generalizable"?	Even if this experience is contextualized in a European country, it could be adapted in other countries. Journal club has a long and international history in medical education. The participatory, interdisciplinary, and creative components of our experience represent also the principal guarantee for its reinterpretation and reproduction, following local traditions, cultural interests, environmental assets, and participants resources

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Chapter 18
Teaching Clinical Skills and Health Promotion Using Clinical Simulations

Maria Helena Favarato

Contents

The medical course on our campus started in 2016 and has as methodology the active student-centered initiatives in an integrated curriculum and insertion in the fields of practice, especially primary care, since the beginning of the course, contextualizing the acquisition of professional skills in vivid and real practice in the national public health system[1]. The competence profile of the graduated professional consists of generalist, humanistic, critical, and reflexive professional performance, with the ability to act in different settings and areas of healthcare, according to ethical principles and comprehensive care, with social responsibility and commitment to the rights of citizenship and human dignity. Within the competence profile, there are those related to healthcare and attention, both individual and collective; health work management and evaluation; and health education, promoting the construction and socialization of knowledge both individually and collectively, both for healthcare and for generating scientific evidence (Padilha, 2016).

Clinical skills curriculum promotes simulations with professional actors in the role of patients or family/companions, to interact with students. It explores cognitive, attitudinal, and psychomotor capacities that underlie clinical practice, with emphasis on the area of attention to individual health needs and elaboration of therapeutic plans. Academic activities are weekly, with a workload of 5 hours per week. Scenarios are elaborated according to prevailing situations in the different life cycles and the proficiency profile of the student, according to the stage of the medical course in which they are. In the first learning cycle, first and second years, the scenario is that of primary care, particularly the Family and Community Health units (Favarato et al., 2019). In the first semester, general goals are related to empathy, creation of bonds, knowledge of the concepts of health promotion and family health strategy, and identification of health needs in young individuals with no

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known comorbidities. The briefing for these students is to genuinely know the other person. For the second stage, the discussions move toward formalizing anamnesis, starting the clinical examination and identifying health needs for individuals with chronic diseases. In the third and fourth semesters, there are specific objectives such as clinical exploration of large syndromes and completion or the fifth and sixth semesters, the skills of constructing clinical reasoning and of the complete clinical examination, with recognition of normality patterns. Elaboration of hypotheses and differential diagnosis are deepened, with diagnostic and therapeutic planning in specialized care settings. In the seventh and eighth semesters, emergency and inpatient care are addressed. In this way, competencies related to health promotion are worked longitudinally from the first to the eighth semesters of the medical course, initially being the focus, and then within the context of patients with clinical complaints and acute and chronic diseases, congruent with common medical practice.

Thus, the simulations allow the student to reflect on the areas of action regarding comprehensive individual healthcare, enabling them to approach the understanding of health promotion at their individual level, with the understanding of the individual as an inseparable unit and with the possibility of action in the various possible disease prevention fronts in the context of primary and individual care. Table 18.1 summarizes competencies related to health promotion that are addressed in this activity. The presented cut of the competences was selected from the political-pedagogical project of the Medicine course of the institution (Padilha, 2016).

Dialoguing with WHO health promotion concepts (WHO, 2021), we have:

- The three basic strategies for health promotion, "enabling, mediating, and advocacy." In our activities, students are encouraged to develop care plans that should

Table 18.1 Summary of health promotion related competences (Padilha, 2016)

Competence area: Healthcare – care for individual and collective health needs		
Identifies individual health needs	Performs anamnesis and clinical history	Ethical relationship, bonding, clear guidelines, life context and biological, psychological and socioeconomic-cultural elements related to the health promotion and disease process
	Perform clinical examination	Clarifies procedures, obtains consent, obtains anthropometric data, vital signs; conducts general clinical examination, cervical, pulmonary, cardiac, abdominal, dermatological, and neurological and recognizes the normality patterns
	Formulate and prioritize problems	Considering the personal, family, occupational, epidemiological, environmental, and other relevant contexts. Informs and explains the problems
Builds and evaluates care plans	Develops care plan	Pacts care about actions with other professionals. It contemplates dimensions of self-care and health promotion. Search membership
	Accompany and evaluate plans of care	Explains and guides, verifying understanding. Properly record the plan in the medical record

be agreed with patients, adapting proposals to individualized needs and possibilities enabling them to develop communication, education, mediation, and negotiation skills.

- Relating to key action areas of health promotion:
  - To strengthen community action: since students simulate situations within the territories related to family health teams, the concepts might be expanded for training and intervention in the community. This kind of activity also dialogues with "creating supportive environments for health," and we aim to develop health professionals that are reflective and critic to reorient health services toward preventing diseases and promoting health.
  - To develop personal skills: individual care is reinforced and resumed so that the students are able to reliably train patients for good health actions.

Considering the core competencies for health promotion from the Executive Agency for health and consumers, health promotion knowledge and ethical values are the key components of the competences. Reflection and theorization of the simulations may enhance motivation to study and deepen theoretical and conceptual knowledge of the students. Ethical aspects are discussed with the actors' view and during the feedback and reflections. Leadership and communication are addressed and trained with simulations and their feedback, with the look of assessing needs, planning, implementing, and evaluating, resulting in change, and advocating for health. Levels of complexity of each situation can also be discussed as students participate in simulations from first to fourth medical years. (Dempsey et al., 2010, 2011).

Since the activities of this discipline occur longitudinally during the first 4 years of medical school, the student is able to experience various situations that dialogue with each other, consisting of a window of opportunity for understanding the importance of medical appointments with a preventive approach, as well as how to develop skills in agreement and preventive counseling. The intention is that the student can build skills related to the promotion of individual health and that he/she knows how to use tools that contribute to the prevention of diseases in all care scenarios that he/she goes through.

Concerning the adopted methodology, students are divided in groups of 8–12 students to one professor. Professors are all physicians with clinical and teaching experience. The simulation cycles consist of 4 weeks of activities: 2 weeks of simulation and 2 weeks of reflection on the simulated practice, including the formulation of learning questions and the search for information in scientific literature.

On the first day of the semester, students are invited to present themselves based on their perceived strengths and difficulties for clinical practice. Pairs are formed that are complementary in their strengths and difficulties. During the 2 weeks of simulation, each student performs one consultation or home visit and observes his pair with the briefing of peer evaluation. The cases are elaborated in mirror, having similar aspects and divergences whose joint discussion is considered enriching. The teacher, after guiding the pair, must clarify that during the entire simulation, the teacher should not be called or asked. Therefore, the understanding and agreement

for carrying out the activity must precede the beginning of the simulation, after which, any decision or indecision and any doubt must be part of the simulation. The simulation starts with the student's contact with the simulated patient and ends only when the student leaves the simulated house or refers the patient to wait at the reception until again being called to see a professional at the unit, or else the student leaves the room in search of that professional, just as if it were happening in a real setting. This closing or forwarding movement is part of the simulation and must be completed so that it can be observed by the teacher. This strategy aims to place the student in a deeper way in the simulation, avoiding a very explicit situation of "make believe" or "freeze/thaw." The teacher stays in a proper environment for observation, where he can observe without being seen.

Students have up to 40 minutes to simulate. Practice simulation feedback movements are:

(i) Student who simulated does his self-evaluation: It is essential that the student self-evaluate himself after the simulation. This "exit" from the simulation brings relief and relaxation. A simulation is always a moment that involves relative tension, since it requires a shift in the focus of attention from one's needs to the needs of the patient. If the student is more concerned with his own performance and with the teacher's assessment, he will hardly be able to focus on the patient and the needs he brings.
(ii) Simulated patient shares his/her feelings: This sharing should not be technical (actions that were supposedly or not technically adequate in the anamnesis and/or clinical examination), but should reveal if he/she felt respected, considered, welcomed, and oriented; if their doubts have been answered; whether there was clarity in the communication; whether the tone of voice was clear and audible; whether he/she was informed about what was going to happen, etc. Following, the simulated patient leaves the scenario.
(iii) Student who observed makes his assessment: For this assessment there is no specific guidance, but the student can talk about the positive points and the points to improve including technical aspects
(iv) Teacher requests clarification/justification of aspects that were not explained in the student's self-assessment to understand any performance that was not clear.
(v) Teacher gives his/her feedback: based on actions and phrases spoken by students, to highlight timely actions and identify gaps related to knowledges, behaviors, and skills.
(vi) Teacher and students build up an individual Improvement Plan, containing knowledge gaps that must be addressed in different ways: self-directed study, activities with laboratory monitors, changes in the next simulations, and sharing in the small group.

This moment generates a written production, which combines the patient's medical history with a reflective narrative about the experience. The narratives must correspond to the lived experiences and bring what the student considered as "critical," in the sense of reflecting on a special effort, decision-making, and actions with their respective consequences. They must point out the contradictions and questions

involved, both in relation to their values and performance and of the other mobilized participants. The possibility of the narrative to contemplate different positions of the different actors involved is already an exercise in expanding possibilities to read and analyze the situation

In small groups, students problematize the content of narratives and stories with the help of the facilitator and generate their learning questions that, after searching for scientific evidence, will be shared with the group.

Active methodology based on problematization is used for the discussion of narratives or histories. In this way, students are invited to read carefully, critically, and reflectively the material created by each of them, synthesizing the set of impressions, experiences, and clinical information collected. In a collaborative way, the group of students identifies problems, which are characterized as unknown information, discomforts, difficulties, vulnerabilities, and health risks identified during the clinical encounters as well as patients' complaints and diseases. The problems are divided between students' (discomfort, lack of knowledge) and patients' problems with preventive, diagnostic, and therapeutic approaches and should be listed in such a way that all group participants are represented in this compilation.

At this point, the role of the facilitator is to question the group of students, making them reflect on the completeness of medical care. Thus, if problems related to emotional or social aspects, as well as health promotion, were not raised, the teacher should question and exhaust these categories of subjects. The next move is the formulation of explanatory hypotheses, integrating prior knowledge and opening up possibilities for objective and subjective interpretation in light of the discomforts faced. The need to explore such hypotheses leads to the formulation of learning questions that represent the learning needs of the students. The questions should focus on aspects that allow the group to broaden their understanding of the situation (Lima, 2017).

As for the evaluative process, we have formative evaluation throughout the course, portfolio evaluation, assessment formats of the learning process, and evaluation of simulated clinical practice. To support evaluation and feedback, teachers use mini-CEX tool (Holmboe et al., 2001). Thus, the student's movement toward the desired competences is identified and exposed and dialogue with him.

We consider this approach of simulation and combined reflection/problematization as a differential of our activity (García & Moya, 2016), as well as the way in which the scenarios are structured, with a wealth of details and deepening in biological, emotional, and social details. The verisimilitude of the situation is made even greater by the ambience of the simulation rooms, as well as the fact that they are professional actors with specific training for our activities (Pate & Ricardo, 2016; Bokken et al., 2008).

The first complete example of scenarios is given in Box 18.1, and one more case is briefly exemplified.

The second example brought is a scenario that is used in the fourth semester. Students are then studying oncogenesis and cancer as the main subject of our integrated curriculum. A 36-year-old man seeks care at a basic health unit complaining of pain in the left lower back, with irradiation to the groin and scrotal region of the

Box 18.1 Simulation case 1. Example of a complete script

Simulation Case 1

Target Audience: first semester students

Scenario: home visit. Students are asked to know the person, to listen to her, to identify health needs, and then to elaborate a care plan that must be agreed with the patient

Case summary: A 20-year-old woman, known since childhood by residents of the region, first because her grandparents are well-known and second for her own skills. She considers herself healthy and does not understand very well how the students or primary care staff could help her, but she is open to talking to students in a spontaneous and collaborative way. Her main characteristic is perseverance, which leads her to do everything with the utmost care. She is usually satisfied with the results of her works, and she thinks her customers- people from the neighborhood- do so. Her new challenge is to attend gastronomy college, and for that she has made some "sacrifices," and she is always tired, the reason for her grandmother to request a home visit.

During high school, which she completed at the age of 18, she started selling candies at the private school where she had a scholarship, to help supplement the income at home. She always tried something different, like gingerbread, pot cake, and cookies, and everyone always liked it, and even students from other years came to buy their delicacies during breaks. After high school, she got a job at a bakery and asked to stay in the cake section, where he met a local cake maker, who gave her many tips. At the same time, she continued to receive orders and baked cakes to sell at the church, at the door of the neighborhood cinema, wherever she went. After a year she asked to change the shift at the bakery: she would like to work at night so she could study during the day, as she decided to attend gastronomy college. Now she works from 9:00 pm to 6:00 am and stays at the cashier, as she has no need for more employees in the bakery or kitchen at night. She arrives home at 6:30 am, sleeps until 10 am, wakes up, drinks hot chocolate, and studies for the entrance exam. She uses used handouts bought online and follows YouTube videos to study. At noon, she starts producing cakes and sweets for orders and brigadeiros which she sells to the bakery where she works. They buy 200 fresh brigadeiros every day, which she delivers at 17 h. During this period, she eats cake fillings, pieces of sweets, and brigadeiros. At 5 pm, when she delivers the brigadeiros, she usually orders a savory at the bakery, with orange juice. Then she goes out to make other deliveries and sell the sweets in the neighborhood, staying on the street until it is time to enter the bakery. She has been in this routine for a year, and it has been increasingly difficult. She has been feeling unwell, having difficulty falling asleep when she arrives from work and very tired during the day. The weight is stable, at least she has not lost any clothes yet. She has been feeling irritated, and even fought with her grandparents a few times.

(continued)

Box 18.1 (continued)

She is an only child. Her parents died in a car accident when she was 1 year old. Since then, she has been reared by her grandparents. Her parents were teachers at the school where she studied, which is why she always had a scholarship. They live in their own house, with basic sanitation and garbage collection. Income is made up of the bakery wages (2 minimum wages), which comes from orders and sales of cakes and sweets (3 wages), her grandfather's retirement (2.5 wages), and her grandmother's seams (1–2 wages).

She was born in the county hospital, after a desired pregnancy. Her parents were well-known teachers and her maternal grandparents, too. Her parents, whom she does not remember, were around 30 years old when she was born. The car accident occurred on a road when she was 13 months old. That day, she was at the home of her maternal grandparents, while her parents were going to visit her father's parents. A truck crossed the road and the two died instantly. She doesn't like to talk about the subject, and if the student insists on some details, she asks to change the subject. Her determination and perseverance have been recognized by the neighborhood.

She likes to work in the bakery and will be forever grateful to the senior colleague that worked with the cakes, because she thinks that even in college, she will not find someone so good and generous to teach her. The relationship with colleagues at the bakery is cordial, but she misses getting hands dirty, and she thinks staying at the cash register is nowhere near as interesting as the pastry shop.

The relationship with her grandparents is affectionate, and she is saddened to recognize that one day her maternal grandparents will no longer be with her. With her paternal grandparents, she has a more distant relationship, but she likes them a lot, and she used to visit them every other week, but since she started making candy more seriously, it has happened once a month, or every other month, being more sincere.

She does not speak directly, but she implies that she is "on the verge of a nervous breakdown," as she does not sleep, does not eat well, and has no leisure time. She broke up the 2-year courtship because the routine did not allow meetings. One hour she is crying, another irritated, another sleepy, but she no longer remembers what it feels like to be well. She always thinks that she is below what is necessary, whether in studies, in the confection of her sweets, or in the relationship with her grandparents. Sometimes, when she stays at the door of the churches, she wants to go in and believe in something that will bring her a little peace, but she can't feel anything when she comes in, and she has tried several religions. She reports an anguish that does not pass, a feeling that her dreams will not come true and a constant tiredness and fatigue. She sleeps from 6:30 am to 10 am, sometimes napping for 15–20 minutes in the afternoon while the cakes are in the oven.

She smokes conventional cigarettes occasionally. She always has a pack, but she smokes when she is very tired, consuming one to two cigarettes a

(continued)

Box 18.1 (continued)

week; the others, distribute when asked. She has no habit of drinking, just a beer when with friends, but she has not had a drink in over a year. She denies use of any illicit drugs.

She has never felt any kind of malaise or pain before; she has never been admitted to hospitals, she has no allergies, and she does not routinely use any medication. Vaccines are up to date, because last year she went with her grandmother to get the flu vaccine, and the nursing technician at the clinic updated her card.

Her parents were healthy. Her grandmother has high blood pressure, while grandfather is overweight and smokes a lot. She doesn't know about her paternal grandparents.

She started sex life at 18. She misses dating a bit, more for company than sex. They used condoms in all relationships. Since dating, she has had no other partners.

Guidelines for the Teacher and Educational Intentionality

The station allows the simulation of a home visit, in which the student meets a 20-year-old woman, single, with a history of life and peculiar habits, favoring the discussion of several risky behavioral aspects. Irregular sleep and poor eating habits, as well as psychological stress, will trigger a discussion about lifestyle, insecurity about the future, and health promotion practices. This situation makes it possible to identify health needs. During the anamnesis, the consultation will reveal life habits and social behaviors that will cause the student to ask questions and initial associations. The situation favors the exercise of an interview in which the student must ask questions that lead him to get to know the person under care better, seeking to identify her life trajectory, finding elements in common with his own life, and the health needs for the elaboration a care plan to be agreed with the person and validated by the medical preceptor. It also makes it possible to discuss the various aspects of verbal and non-verbal communication that make up the patient-professional relationship, working mainly on empathy and the formulation of predominantly open questions and without the expression of value judgments.

Some points to be discussed:

- The role of the Family Health Strategy and home visits
- Defnition of health promotion
- Care goals for young patients without specific symptoms
- Inadequate eating habits
- Irregular sleep rhythm
- Psychic stress
- Depressive symptoms
- Sedentary lifestyle

  Lack of pleasant practices and habits

same side. The pain was of moderate intensity (5–6) becoming of strong intensity (8) during the night. He urinated blood on waking and became very scared. He was especially worried because his girlfriend's grandfather has bladder cancer and always has blood in his urine. He did not take any medication; he is just very scared and wants to do "all the tests" to see if he has cancer. He also knows two neighbors and a 16-year-old cousin who have been diagnosed with cancer. In this scenario, the patient has a sedentary lifestyle and consumes alcohol frequently and occasionally uses tobacco. In addition, he has unprotected sex. This situation allows the student to explore the clinical complaints brought by the patient, which probably indicates urolithiasis. Meantime, aspects related to health promotion are as important as the main acute complaint, as it is necessary to reassure him that his symptoms are not suggestive of cancer. An opportunity is then created to explain to the patient the specific situations in which cancer screening is indicated and make the individual aware of lifestyle changes that are interesting for cancer and other diseases prevention.

The principles of health promotion are based on empowerment, participation, and collaboration, aiming to increase control over health and health determinants toward a state of well-being. The focus of practice should be to address the contexts and meaning of health actions and the protective and enhancing factors that keep people healthy (Dempsey et al., 2010). Under this understanding, calling students to genuinely know their patients, to comprise social and emotional aspects in their care planes with shared decision of priorities, and to make them practice and reflect on the needs and possibilities of their patients is to strengthen health promotion in the prints of these future physicians.

Since the skills related do Health promotion and counseling are important in the practice of health professionals, it is important to develop these skills and attitudes during undergraduate courses, with strategies that use simulation as an interesting alternative (Reynolds et al., 2020), since dramatization in the context of clinical simulation has been associated with gains in, among others, clinical and communication skills, empathy, self-confidence, teamwork, critical thinking, motivation for learning, capacity to use background knowledge, and opportunity to reflect on practice (Romero-Collado et al., 2020; Negri et al., 2017; Lubbers & Rossman, 2017), which are all required competencies for the best performance of individual health promotion. The educational experiences found in the literature that discuss the use of simulations and standardized patients for the acquisition of skills in health promotion were carried out with nurses or nursing students. Thus, in addition to our pioneering proposal in the sense of bringing this methodology to medical students, the unfolding of reflection and problematization based on simulated clinical practice is also innovative (Yoshioka-Maeda & Naruse, 2021).

The fact that they have to reflect and write about the experience leads students to perceive themselves in action, leading to the identification of knowledge gaps, strengths, and difficulties for the performance of professional practice, with reproducibility and patient safety (Negri et al., 2017). The sharing of evidences and conceptual and cognitive knowledges in the small group also helps build an ethical and evidence-based practice of health promotion. The possibility of repeated meetings

and the longitudinality of our program are also differentials in comparison to other health promotion teaching strategies in medical schools.

Table 18.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 18.2 Authors´ reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	My personal view is that, with a focus on individual care, the practice and teaching of HP support essential strategies for patient care in any setting, constituting the most important pillars in daily medical practice
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	In the institution, the clarity with which the need to train doctors qualified to practice in primary care makes the environment favorable to HP initiatives. However, there are some teachers who are still very specialized and with a traditional teaching mentality who have difficulty in incorporating concepts and practices in teaching activities
Which theories and methodologies are used in the teaching-learning process?	The methodology used is active and student-centered, based on simulations and individual and joint reflection in the small group on practices. The construction of knowledge takes place in a gradual and continuous way, with the valorization of previous knowledge and experiences and directed observation with individualized feedback for each student, who, at each meeting, draws up an improvement plan
What kind of forms of assessment are applied, results achieved, and challenges faced?	Each meeting ends with an evaluative moment, where the student makes a self-assessment and assessment of the group and its facilitator, in processual and formative assessment. There is construction and dialogue about the individual portfolio of each student, in which the trajectory of approximation with competencies is valued, with the reflexive aspect being particularly important. There is twice in the semester a moment called evaluation of the learning process, in which the performances in the simulations, the activities of theorization and construction of knowledge, sharing of searches, portfolio, and fulfillment of work agreements are considered, with evaluative contributions from the student himself, his colleagues, and the facilitator
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	Considering the core competencies for health promotion from the Executive Agency for health and consumers, health promotion knowledge and ethical values are the key components of the competences. Reflection and theorization of the simulations may enhance motivation to study and deepen theoretical and conceptual knowledge of the students. Ethic aspects are discussed with the actors' view and during the feedbacks and reflections. Leadership and communication are addressed and trained with simulations and their feedbacks, with the look of assessing needs, planning, implementing, and evaluating, resulting in change, and advocating for health. Levels of complexity of each situation can also be discussed as students participate in simulations from first to fourth medical years

Questions	Take-home messages
What could others learn with your experience? What is localized, and what is "generalizable"?	Others may be confident in applying simulations to develop health promotion skills for the training of health professionals. We have included in the text details of how we do the simulations, and we are available to discuss with any readers who have questions for the preparation of scripts that favor this type of discussion. Still, the role of reflection is emphasized, and this can easily be extended to other scenarios. The fact that the simulations are carried out with professional actors and the discussion takes place in small groups with a medical facilitator for every 10 students raises the costs related to the course

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Chapter 19
Learning Health Promotion from Skateboarders: A Community-Based Practice to Rethink the Academy Teaching Method

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Contents

Introduction

Skateboarders are members of a social group and constantly negotiate their presence in the urban space. The practice was born in the USA and arrived in Brazil around 1970, becoming one of the country's most practiced sports, whose

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popularity increased after the inclusion of the street skateboarding modality in the Tokyo Olympic Games in 2021. Although this inclusion raises a debate about the commercialization of the practice, this media visibility casts new perspectives on the acceptance and presence of skateboarding in the urban landscape. The historical construction of skateboarding in the streets occurred with teenagers and young adults, marked by the counterculture tendency. It was common to see skate culture associated with crime and civil disobedience. Despite representing one of the most practiced sports globally, in Brazil, skateboarders are stigmatized, often associated with drug dealers or users and vandals, marked in the social imagination of the middle class as a population that misrepresents social values.

There are also constant correlations between skateboarding and health risks, even if indirectly, with many relations leading to the theme of violence, framing the skateboarders initially under the eyes of ambulance sirens and later on in the sights of other sirens. The scientific literature almost exclusively relates the practice to the incidence of falls and injuries suffered by practitioners (Feletti & Brymer, 2018; Forsman & Eriksson, 2001; Kaddis et al., 2016), recommending it only for a specific age range and in limited spaces (called skate rinks). Although it is not possible to ignore the health risks of skateboarding and any other radical sport, it is also not possible to ignore the benefits and the social constructions established by the collective perception of their practitioners, whether or not induced by the media or the science.

This narrowed view on the practice of skateboarding disregards its cultural and social interlocutions, its role in urban spaces, and the strengthening of communities (Adamkiewicz, 1998; Howell, 2001); these qualities make them truly health promoters. However, they have faced social conflicts due to their differentiated mobility concerning pedestrians or drivers. The theme emerged in 2019, in a discipline called Groups and Networks, included in the health promotion graduate program of a private university in the south of Brazil, when a student, an artist, and skateboarder challenged students and professors.

This chapter aims to present the main events that emerged when a bottom-up learning approach was applied. The main focus was to include a group of skateboarders as central to the debate of the practice and health promotion theory. In addition, we showed the importance of connecting our students with urban community members, especially those currently marginalized and stigmatized. The reflections that came up after the contact with skateboarders allowed us to strengthen community work and a more effective participation by the university, bringing knowledge to communities and from communities into the classroom. The details of the development of the teaching-learning process will be presented below.

Development

The Experience Context

The health promotion graduate program (master's and doctorate) of Cesumar University, in Maringá, south of Brazil, was created in 2011 to cope with the growing need for vocationally trained professionals in different fields of knowledge and in line with the National Health Promotion Policy implemented in Brazil in 2006 (Ministério da Saúde, Brasil, 2006). At that time, human resources formation and research initiatives in health promotion were outlined, with a summary of the obstacles that needed to be considered in order to ensure the effective implementation of health promotion in the future (Buss & de Carvalho, 2007). Since then, this graduate program in health promotion has been requiring the study of local environmental problems and urban/rural development from an interdisciplinary perspective. Thus, the focus strategy of the problem-solving action adopted is often a "community-oriented" approach using the "problem-solving" method of teaching and learning. The aim is to produce professionals with solid convictions and the urge to meet the community's health needs, considering interdisciplinarity as the center of actions.

The critical contribution of health promotion in solving community health problems, including its relevance to operationalize the 2030 agenda for sustainability (Fortune et al., 2018), led the health promotion graduate program to create, in 2018, a discipline entitled Groups and Networks, which deepens the debate on the potential of knowledge built focused on the community.

In this discipline (offered every 06 months), students develop participatory projects that aim to strengthen the links of the academy with the community in solving problems, especially those that emerge from people in social vulnerability conditions. Professors from different areas of knowledge (humanities, social, and biological sciences) and students from other courses (arts, pedagogy, medicine, psychology, physical education, nursing, engineering) usually take the subject, in which students can bring up the problems to be discussed in the classroom. For example, the experience reported in this chapter, "urbanization and health promotion through the eyes of skateboarders", was brought by a student who graduated in arts.

Theories and Methodologies Used in the Teaching-Learning Process

Reaffirming the contribution of health promotion to improve the quality of life of individuals and populations, the teaching process of health promotion theory considers the importance of community experiences in facing the determinants of health in its entirety. Furthermore, it anchored the relevance of implementing healthy public policies, effective intersectoral articulation of public power, and mobilization of the population (Buss et al., 2020). This model of education

dialogues with the principles of the brazilian educational philosopher Paulo Freire, who indicated in his liberating learning theory a horizontal teaching method where everyone teaches and learns (Freire, 1970). In the case of the "Groups and Networks" subject, this was incorporated initially, with no lecture-type classes. In Paulo Freire's perspective, skateboarders had elements that would teach us about the concepts of health promotion, and it was up to us to observe, dialogue, and learn. Indeed, Freire's methodology is based on the humanization of teaching and recognizing the student's history and culture. Fifty years after its initial publication, Freire's *Pedagogy of the Oppressed* remains a vital force in contemporary education. It has increasingly nurtured the pedagogical principles of teaching in the health field, especially health promotion. At the heart of Freire's work lies a radical proposition: education must become a "practice of freedom" that develops "critical consciousness" among its learners (Freire, 1970).

Such concepts have been built on a history of community participation from the Ottawa Charter Health Promotion call for community mobilization, to the emancipatory concept by Paulo Freire, to social movements and organization for health and social justice (Wallerstein et al., 2017). Furthermore, the relationships established between Freire's thinking and health education have provided the understanding that health education strategies should focus on collective knowledge, the latter being the result of group dynamics produced from the discussion of shared experiences and their analyses to create understanding (Mooney & Nolan, 2006; Van Wyk, 1999).

This movement of including communities in academic debates is not exclusive to health promotion; medical schools have increasingly promoted the inclusion of social responsibility in their mandates. As such, they are focusing their attention on the social determinants of health as key factors in the health of patients and communities they serve (DasGupta et al., 2006; Sharma et al., 2018). However, underlying this emphasis is the assumption that teaching health promotion to students about the social determinants of health will not help them to achieve health equity; it is necessary to go further. A significant move to be made by universities is opening the gates to the community, allowing social inclusion in its essence, valuing the communities' innate knowledge, and allowing students to access it. The community-based teaching model has already been adapted to different contexts (Morais et al., 2021; Ozone et al., 2020; Rhodes & Sy, 2020), with promising results in the area of health promotion, especially concerning the collaboration of this area in coping with health crises we have been experiencing (Levin-Zamir et al., 2021; Yamada et al., 2020).

Principles, Pillars, Competencies, and Approaches to Health Promotion

Following Brazil's National Health Promotion Policy, the valorization of social constructions originating from communities, especially those permeated in the context of social vulnerability, is the basis for understanding the ways of living. Therefore, by attending the subject of "Groups and Networks," we believed that the health promotion students were able to be aware and to apply these principles and also to experienced community mobilizations, recognized here as "a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health and other needs, either on their initiative or through the health advocacy of others" (Nutbeam & Muscat, 2021, p. 9).

Although its principles are widely adopted, opportunities to transfer these principles into the radical changes and practical solutions needed globally to improve health have been difficult to implement in the teaching of health promotion at the university. Even in the face of difficulties, a health promotion curriculum must follow the principles of health promotion, allowing people to increase control and improve their health. In this sense, the teaching method must include participatory decision-making approaches, as previously suggested (Bhuyan, 2004; Meier et al., 2007). Even though classic subjects in the health field, such as public health policies, epidemiology, and collective health, discuss about the paradigm of health promotion, the tone of the discourse is most often centered on the power that knowledge has over health behaviors.

In this context, there is a classic tendency to encourage the construction of knowledge based on the assertion that behavior change strategies are effective. As well debated by other authors, the empowerment of populations is a primary objective of health promotion, acquired if strategies are articulated beyond the simplistic view that health behavior change is the only path to be followed (Nutbeam, 2008; Tengland, 2016). The choice of behavior change model increases the students' difficulty in understanding the meaning of empowerment in health, perpetuating neoliberal principles of accountability of problems for individuals, exempting the role of the State. In this context, the biomedical method of building knowledge stands out, since most health promotion interventions are guided by the conduction of "more" adequate ways of living.

Reflecting the shift in the emphasis of the curriculum, the health promotion graduate program at Cesumar University revised the framework of reference subjects for health studies to produce professionals with knowledge, understanding, and subject-specific transferable skills relevant to the twenty-first century. Furthermore, as a result of this curricular restructuring, other disciplines beyond the Groups and Networks, such as Technologies in Health Promotion, Education and Health Promotion, Health Economics, and Health Promotion for Vulnerable Population, were implemented.

On the other hand, it was not enough to implement new disciplines; it was also necessary to innovate the learning method, and it was in Groups and Networks that the theme "urbanization and health" made it possible for students to seek community representatives to start a study project. Unusually, one of our students (graduated in arts) invited a group of skaters to participate in the project. It is precisely the experience of this initiative that we report in this chapter. The methodological proposal is in line with the importance of community mobilization to put health promotion theories into practice. Then, the coordinator added two main competencies to the graduate program curriculum: (a) the ability to identify and resolve problems of vulnerable groups and (b) the ability to articulate the different social actors to improve healthy public policies.

The Teaching-Learning Project: "Urbanization and Health Promotion Through the Eyes of Skateboarders"

The teaching-learning strategy used in the subject had different stages: (1) recognition of the theme "urbanization and health promotion" by the students and contact with the group of skateboarders; (2) exchange of knowledge and experiences between skateboarders and students; and (3) the evaluation process.

Recognition of the Theme by the Students and Contact with the Skateboarders

On the first day of Groups and Networks class, during the recognition of the health promotion topics, the students suggested that they could debate the theme "life in the city." During brainstorming, one of the students (graduated in arts and skateboarder) proposed the subject "urban aggressiveness," raising relevant issues about the skateboarding practice in the city. In addition, the student also questioned the role of health promotion in strengthening society's resistance to skateboarding, highlighting how scientific literature in the biological area addresses skateboarding, classifying the practice as a dangerous sport. According to the student, this limited view contributes to the stigmatization of skateboarding by society. In his speech, the student reinforced that the city's skateboarders knew different aspects of urban policy and health, which we could use in class.

No student in the class had thought of this group as relevant to health promotion, even though the skateboarders occupy several urban spaces in different cities worldwide, being expressive in marking a culture and a way of life. The group then decided that the teaching project for the subject would be carried out that year on the theme "urban aggressiveness and its relations with health promotion" and that skateboarders from the city could be invited to participate in the project. The next step was to get in touch with the skateboarders. First, the students discussed which

locations in the city they could find skateboarders easily. Then, during a week, the students were aware of the presence of skateboarders in the city, and after that, they listed several locations where they could be approached.

Thus, the artist student (with the skateboard under his arm), other students, and the professors mediated contact with the skateboarders. During the conversation, the skateboarders reported different challenges, improvements they made on the space, and the contribution of their practice to the health of the city. From this contact, community-based participatory research was developed by the students, which result is presented below.

The Exchange of Knowledge and Experiences Between Skateboarders and Students

During the initial contact with the skateboarders and in the subsequent dialogic circles, the skateboarders showed some images recorded on their smartphones of different situations they faced in the city. This imagery documentation gave insights to one of the students, who proposed a Photovoice method to develop the teaching-learning project. The group of students then deepened the technique and evaluated its applicability with the skateboarders considering the objective of the project. Thus, the students created a group in the WhatsApp application, in which all situations experienced by the skateboarders were archived and shared, as suggested by the Photovoice method.

Therefore, the students use community-based participatory research (Wang & Burris, 1997) to analyze the skateboarders' perception of their performance in the urban space and how they experience "urban aggressiveness" (events and physical locations, spatial configurations of the city that negatively affect the skateboarder or other individuals in the city). We believe that it could provide students an interdisciplinary view of the practice and theory of health promotion. Indeed, this strategy enables people to identify, represent, and improve their community through photos. One of the axes that supported the approach is inspired by the dialogical and educational perspective presented in Paulo Freire's theory, which describes narrowing the distance between individuals who live in a given context and recognizing their reality as a political phenomenon.

Therefore, the scientific literature recognizes the Photovoice method for accessing communities and inviting them to create narratives about their realities through recording images and critically discussing records to share ideas. As a result, the method tends to assist in understanding the characteristics, quality, weaknesses, and problems of the communities. Others have already shown the use of the Photovoice method in a different context; however, we report for the first time the use of this method as a possible tool in the teaching-learning process of health promotion.

To conduct the Photovoice technique, we followed the steps suggested by Wang (1999). Initially, several skateboarders were invited, and 20 accepted to participate in the WhatsApp group, of whom 12 sent the photographs and their narratives about

the city. They were 11 male and 1 female, with ages ranging from 19 to 38 years (Table 19.1).

The collection of photographic data took place for seven consecutive weeks (May and June 2018). During this period, the skateboarders took photographs using their smartphones. The initial theme for photographs was to produce photos about how the skateboarders act in the city and what they see as aggressive situations in the urban space when they practice skateboarding. At the end of the period, students invited the skateboarders for an interview to contextualize and discuss their images.

The interview process used the SHOWeD strategy: What do you *See* here? What is really *Happening* here? How does this relate to *Our* lives? *Why* does this situation exist? How could this image *Educate* the community/policy makers/etc.? What can we *Do* about it? (Wang & Burris, 1994). After the interview, the skateboarders selected the best images to compose the final analysis, writing subtitles.

A total of 40 photographs were selected by the 12 skateboarders and combined with oral narratives about them. During this stage, many relations were made between health promotion and urban aggressiveness, some of which can be read below.

On the Occupation of Urban Spaces

Students explored how skateboarders express their perception of the urban space and how it allows a reflective posture on urbanism and health promotion. The skateboarder's stance in the city refers to a critical reflection of the function of spaces. So, when the skateboarders' perception of the town is shared, this cultural expression broadens our vision of urban functionality and inspires us to think of other ways of seeing the potential of spaces for people. Furthermore, the feeling of freedom,

Table 19.1 Characterization of skateboarders and their contribution

Name	Age	Practice time (years)	Photos uploaded	Selected photos
Eduardo	33	20	23	3
Ezequiel	19	6	32	3
Fernando	23	8	11	4
Gabriel	25	10	5	5
João	38	25	20	3
Jonas	21	–	3	2
Matheus	22	11	10	2
Paulo	24	10	3	2
Rafael	36	27	7	5
Susy	24	–	11	4
Tiago	28	18	55	5
Veb	21	5	10	2
Total			132	40

improvisation, and the skateboarders' nonstop action on a movement (trick) indicate that the city does not yet have a predefined function.

In addition, to use public spaces already established in the city, skateboarders also build some obstacles or revitalize environments to practice. That concerns the character of the skateboarding community in the building, adapting, and renovating the places they use, creating new barriers, and improving their conditions of use. Some photographs and narratives can help the students understand how the situation was seen from a skateboarder's perspective (Fig. 19.1 and Table 19.2).

Skateboarders use urban equipment distributed in the urban spaces, such as edges, benches, and handrails, to perform tricks, guaranteeing a new affordance to the space, portraying the individual and the environment (Gibson, 1986). However, the students observed that the statements also show a particular affective attachment to the places of practice described by the skateboarders; in some speeches, they reported on the structural reform they did by themselves and how the community mobilization took part to care the environment. In addition to appropriating spaces, the skateboarders mentioned restoring it and trying to maintain it in the right conditions to guarantee longevity, so that they continue practicing, which confirms the assumptions of *environmental psychology* that demonstrate the importance of the affective relationship between the person and the environment (Bomfim et al., 2018).

These observations lead us to reflect on what kind of relationship was expected when urban designers project space for the citizens. In the last 30 years, public space has been capitalized by the increased construction of private spaces, which reinforces the inequality between social classes. Moreover, the building of spaces for consumption, such as shopping malls, creates a situation of spatial exclusion that contrasts with spaces improved by skateboarders, which will be open for appropriation by any citizen, whether participating in other sports or just for leisure activities.

If, on the one hand, the levels of social inequality and violence are adjacent to the living conditions, on the other hand, the intentions of privatization and security of

Fig. 19.1 Photographs and narratives about the construction of spaces for skateboarding. Ezequiel's photo: raising the manhole cover to use the handrail; and Eduardo's photos: obstacle construction

Table 19.2 Narratives about the construction of spaces

Ezequiel's perception	Eduardo's perception
[...]street expression, bro, something that only a skater or depending on the skater who will use it there, right, like that, it's a utility hole cover, you know? It's a utility hole cover! What citizen will look at a utility hole cover? What will he want to do with a utility hole cover? Doing nothing is there, but like, skater already sees it as a ramp	This fills my heart with joy, seeing that there are people who care about public spaces because most of you see everything abandoned, even practitioners of other sports do not get together, do not have motivation, [...] they tend to charge for government and put all the blame on the government, at this point skateboarding is a very different sport, we do [...]it is very gratifying after having finished seeing the crowd maneuvering, evolving, and everyone taking part because everyone doing a little bit of the stuff happens in a cool way and arouses the interest of other people to be helping, and now it happens directly

Fig. 19.2 Photographs and narratives about the re-significance of urban space. Rafael's photos: a person resting in the square; skate in the square; skate in the bike path

spaces offer palliative preservation options. Moreover, as already known, the street has a commercial or informational function. Still, there is also a playful aspect, which is symbolic and built by the new practices given by individuals in their relationship with the environment. In this sense, the skateboarders showed the students how we could contribute to the reframing of space by demonstrating how spatial-social connections transform and shape other habits and practices in urban space (Fig. 19.2 and Table 19.3).

For skateboarders, the practice of skateboarding is a cultural manifestation of belonging. However, the occupation of empty spaces can lead to conflict situations experienced by skateboarders when they are questioned by security guards in "not

Table 19.3 Narratives about the re-significance of urban space

Rafael's perception
So, this abandoned square and others here in Maringá, do you look here and what is there? A guy is sleeping there, but it could be busy, have a lot of activities, for skateboarding, for example, if there were only a smooth floor, we would already dominate (laughs) here, have a lot of fun. So, it is more a matter of... I think that I could improve this space that is now abandoned and the disposition of nasty things with small initiatives
The bike path is more of an issue for mobility because I, for example, live there near Borba Gato and go straight to skateboarding. I go on the asphalt [...] there is a question that it is made to ride a bike and everything, but bro, a business I always ask myself: Why is the bike path in Maringá so rough? So irregular? I even asked the people in the architecture department here at the city hall. They said that they make these friezes so that in case of rain it doesn't skid [...] if it is smooth like it is in most places I've been around, you can skate, you can also use the skateboard locomotion, collaborate with the environment, traffic, and everything, you know?

Fig. 19.3 Photographs and narratives about urban aggressiveness. Ezequiel's photos: using the shopping mall wall; approached by the shopping mall's security guards

allowed" places (Fig. 19.3 and Table 19.4). Thus, it is clear that the space is more reserved for consumption and under constant surveillance, as observed in other studies (Cafrune, 2016; Castells, 2018). From this perspective, the students were able to identify that the co-responsibility between people and the State in managing a more inclusive, equitable, and healthy environment is part of the conceptual axes of health promotion. Therefore, discussions about urban aggressiveness are pertinent to the curricula of health promotion courses.

The term "urban aggressiveness" emerged as a counterpoint to the concepts of "defensive architecture," described by Howell (2001) and Borden (2001). Chains, surveillance cameras, and construction of structures with uncomfortable materials and sizes, as pointed out in the skateboarders' photos, make these spaces unpleasant to be and can be seen as examples of this "urban aggressiveness" (Fig. 19.3 and Table 19.4). It is precisely this intention of impermanence that seems to lead to a city that removes some actions from human life, delimiting its spaces and functions to more "socially accepted" actions.

Table 19.4 Narratives about urban aggressiveness

Ezequiel's perception
We decided to use the wall outside the shopping mall to skate on this day; it didn't take long for this situation to happen. When the security guard sees it, he is indignant [...] the person should think a bit like an act of vandalism, right?
There is only one parking lot there, the shops on the corner have been closed for years, it's a dead thing, it's a dead 'little alley' [...]. So, when a person like us finds a use for the place, they must think 'I'm going to have to do something, I'm going to boycott' [...] because every policeman who fits, everyone who approaches you on the street always says: 'Ah! But you have the track over there that you renovated'
I think it happens out of respect for a pattern, you know, I see it like this when they tell me [...] you can't skate here, you have the rink there, you have your space there on the rink, so you can only walk there. So, in this situation, I wonder what their approach would be if I were inside the mall, as a customer, a consumer

In general, we can learn from skateboarders that the perception of urban aggressiveness is associated with a tendency to use urban spaces for consumption, which repels the identity and alternative mobility employed by them. On the other hand, although the skateboarders saw themselves as crucial to the city, their occupation is healthy to the environment, as shown below.

On the Occupation of Social Spaces

According to the skateboarders, the practice of this modality contributes positively to give life to the city. However, they say that some conflict situations are often aggressive.

They reported that skateboarding culture is a lifestyle and a sport related to the street and urban architecture, so the modality goes beyond leisure. It is a cultural practice that includes music, fashion, and art, integrating different ages and genders. Skateboarders see themselves as agents of change who act through collective mobilization and call skateboarding a culture of continuity (Fig. 19.4 and Table 19.5).

About this aspect of skateboarding, some students noticed relations with the Brazilian health promotion policy. This document's specific objective is the call to avoid or even reduce systematic inequalities through participation and social control. On the part of skateboarders, they usually invite non-practitioners to enjoy their actions, even if only for leisure. Skateboarders claim that just occupying public space (whether skateboarding or not) is a political act. What is noticeable concerning the health promotion theory is that reduced inequalities can also occur when different groups are interested in promoting a movement or an action with repercussions on the community. Likewise, the Ottawa Charter (OMS, 1986) reinforces the importance of community action as a health promotion strategy. It occurs because increasing the power of communities in the decision-making process can improve health conditions. We recognize that community development depends on human resources, which proposes that health promotion is greater social participation, autonomy, and control by individuals, evidencing the community repercussions.

Fig. 19.4 Photographs and narratives about skateboarding as a lifestyle. Fernando's photo: my shadow in society. Thiago's photo: celebrating the hit

An important point highlighted by students is that there is a proximity to many of the guidelines that underlie the health promotion's theory in the practice of these skateboarders, especially concerning the planning of territorial actions for the recognition of local contexts, respecting diversity, and improving healthy environments. For example, the skateboarders' speech highlighted the theme of respecting different modalities in the same space, cycling, skating, and others that connected families to leisure activities. The students understood, through the interviews, that a similar concern was also proposed by Ottawa Charter: "creating favorable environments for living."

The importance of community action was highlighted by recognizing people as the primary resource for health, supporting and accepting them as an essential health matter. In this sense, when skateboarders propose sharing their perceptions, they present us with subsidies to think about more inclusive actions in the city and in the community. In light of this, students recognized that getting closer to the skateboarders and supporting them in their activities favor creating and developing healthy lifestyles and public policies.

Table 19.5 Narratives about skateboarding as a lifestyle

Fernando's perception	Tiago's perception
I think that we are an individual from society, there is no way not to accept that. But, as much as we live in the suburbs, we are still part of it. I think the skater has a hard time accepting this reality, and usually, he gets angry with society, but I believe there is no way we can avoid it... unless we create some skate rinks in the bush and live there, understood? [...] no matter how difficult it is for society to accept us, we have to work together on this, you know? So, I think this is the way we should go [...] there is an exciting thing that I heard recently, what changes a country is not exactly the political actions, it is the ideas, they say that when we discuss ideas, over time, we will act according to those ideas. The politicians will observe such thoughts in society, and then they will, shall we say, work according to these ideas to maintain their power. So, I think that this could also be applied to skateboarding. We start to believe in a more open way [...], receive more people, understand that we are part of society	Skateboarding is urban culture, so we are always on the street, always walking or sometimes with the family in the car, looking at a new edge, looking at a new property that has just been built, we look at it with a different view, are you on? We look at that edge and already imagine skating, which maneuver, the photo, the image for the videos, so, this is the vision we have of new spots on the street, we always see this, and we transform it into art. [...] we have this view further, so, I always wanted to record those moments, you know? That frame of life, for people never to forget. It's a freeze from that moment, right? This is very good; the skater is always among friends laughing, and it is always good to be skateboarding [...] on a skate park there is laughter, there is learning, a friend is helping the other, one teaching the other, same thing as in a school, but it is a little more difficult because you are on the street, so valuing is a little bit bigger, learning is a little bit bigger

On the Perception of Health

Most of the scientific literature in the health area relates skateboarding with accidents, falls, and injuries suffered by the practitioners, contributing to a pessimistic view of the sport. The studies that link the practice of skateboarding and the risks of injuries suggest the use of helmets and other safety accessories, limiting the practice to specific locations called skate parks.

Otherwise, skateboarders do not deny that the practice is somehow dangerous. When they try to execute a trick, they do it countless times and feel a sense of well-being associated with persistence and the pleasure of overcoming the difficulty. Indeed, the discussions raised from the reports of the photographs show that skateboarders see biopsychosocial benefits of their practice. In different moments of the interviews, they declared some benefits linked to mental health, such as reducing stress, therapeutic activity, and pleasure (Fig. 19.5 and Table 19.6).

Since health guidelines usually have a biomedical perspective, which reduces health to the simple absence of diseases, the students relate skateboarders' narratives with a more integrative view of health, as a complete physical, mental, and social well-being, as defined in the Ottawa Charter. Many of the reflections brought by skateboarders aim at the social benefit related to friendship and bonds built

Fig. 19.5 Photographs and narratives about skateboarders' relationship with risks and health. Gabriel's photo: pain. Thiago's photo: the challenge

Table 19.6 Narratives about the skateboarders' relationship with risks and health

Gabriel's perception	Tiago's perception
[...] pain works as an incentive; the skater often tries to maneuver for hours, and what happens? For example, in this photo, the skateboarder injured his hand and opened a piece of shin; if it were in any other sport, the athlete would stop, go to the hospital, score points and spend a month without practicing the sport. But, in this case, what happened was the following: He felt, got hurt, and felt tremendous energy to do the maneuver again, to solve this, as if he had been challenged, as if they were saying to him, "No, you will not make it, there is no way do this man," then we are driven by challenges, do you know? [...] Because skateboarding works as an escape valve from problems. I have often found myself in situations where I was stressed with work; at the time I worked at the mall, many charges, I used it as an escape valve, and this is what most people do, you know? So, this is cool because we are doing an exercise that takes us out of this Babylon, this idea of chaos and excessive productivity	[...] we leave the house to finish the maneuver, never leave the house to break our arm, never in life [...]. This is much easier to do on skateboarding because you have four wheels under your feet, going down a two-meter ladder or going down a gigantic handrail, or sometimes, walking down the street, a pebble hang. You go to the ground; you can get hurt; this is dangerous. We always fall and get up; we always fall, get up, and want a perspective on life. I think this is an evolution in your life. With the purpose of skateboarding, you evolve in your work; you become with your family, grows with his wife, his brothers, the benefit is magnificent

during the practice, not only the individual benefit. This can be connected to the health promotion area to empower the community to collaborate in seeking quality of life and health improvements, with autonomy and decision-making. Many other reflections came up from this experiment, such as the attention to space conditions, the feeling of belonging to a group, community engagement, public policies, gentrification, and living in a city as a citizen.

Process Evaluation

Even though there was no specific moment for a formal evaluation, at the end of each day, the students discussed among themselves everything that happened during that day. In this evaluation, the students analyzed two critical dimensions: self-evaluation and analysis of the group's action. The focus given by the students and guided by the professors (acting only as tutors) was to align the ideas with the competencies proposed for the subject: (a) the ability to identify and solve problems of vulnerable groups and (b) the ability to articulate the different social actors to improve healthy public policies.

As for the first dimension, a dialogue circle showed a particular surprise from the students regarding the ability of skateboarders to correctly articulate the concepts of health promotion, even though they did not have the disciplinary training to do so. In addition, some students were surprised by the political articulation of this group and the solutions to face the urban challenges imposed on them. Finally, it led students to understand the relevance of bottom-up knowledge brought by the community, strengthening the importance of opening the university gates to different groups.

However, all the students' contact with skateboarders took place in city spaces because the skateboarders were resistant to cross the university gate. This behavior may be an answer to the skateboarders' bad experiences within the practice of skateboarding in the campus, as some of them reported oppression by the security guards. In addition, students verbalized in their evaluations that the university is a privileged space for knowledge but often distant from the real problems of society and disconnected from urban life.

In their thoughts, the students also identified an attempt to circumscribe the practice to more socially controlled spaces by building skate parks. Also, the presence of skateboarders on the streets and sidewalks triggers meaningful discussions on urban mobility and aggressiveness. A sensitive issue perceived by the students was that the creation of skate parks could hide a policy of segregating the activity to restricted space, showing that the students could identify ideologies behind urban policies. Another critical evaluation carried out by students was the applicability of the teaching-learning method. They emphasize that the technique could be implemented in other health-related contexts, including groups with reduced mobility, homeless people, sex workers, or garbage collectors.

In addition, during many of the events that took place throughout the development of the project, students had the opportunity to integrate content from other subjects, which somehow cut across the situations exposed by skateboarders. The students brought up many of the contents discussed in the main subjects of the graduate program such as "Historical and Conceptual Aspects of Health Promotion" and "Public Health Policies" during the evaluation processes.

Final Considerations

We presented in this chapter how a group of skateboarders getting mobilized to face the challenges imposed by the urbanization process can be taken as a case for thinking about the different relationships between urban life and health promotion. Skateboarders led the students to understand the importance of community in reactivating neighborhoods and using public spaces more enjoyably. Nowadays, socioeconomic constraints lead us to visit more private spaces and be confined in cars, shopping malls, or other closed environments. The practice of skateboarding on streets can be an alternative to these commercial and capitalized spaces. Indeed, the results of our experience showed that the skateboarders could inspire us to rethink the city space more creatively, with a view of freedom and political engagement. Moreover, it overcomes the stigmatized practice that usually associates the practitioners as unproductive individuals, a marginalized group, and drug users.

As for the implementation of the teaching-learning method adopted in the discipline of Groups and Networks, it was possible to observe that students made connections between the skateboarders' narratives and health promotion concepts as follows:

- Spaces and objects in the city may have other uses rather than just predetermined ones.
- The act of taking care of spaces and even repairing it can promote a sense of belonging, which is essential for social co-responsibility (citizens and public authorities).
- The urban space is composed of different actors and interests, and as citizens, we must negotiate them.
- The relationship between citizens and the space must consider different levels, the individual (pleasure, health benefits), the interactional (sense of community), and the cultural (creation of a lifestyle).

So, these connections demonstrated the potential for healthy thinking, social participation in health decisions, and the creation of favorable environments. Thus, we can conclude that opening university gates to the community goes beyond a symbolic act of social insertion. Instead, a more significant effort needs to be made to create a common identity, where students and community members feel entitled to build a more just and equal society.

Finally, this study breaks with the traditional and biomedical discourse linking skateboards to falls, injuries, and pain. It explains that the skateboarders can be invited to discussions related to health promotion. The teaching-learning project was undoubtedly a promising strategy to be implemented in the teaching of health promotion, facilitating the transposition of theoretical concepts into practice, necessary for the training of future health promotion professionals.

Table 19.7 brings our reflection on the six triggering questions suggested by the editors.

Table 19.7 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion is understood as the ability of individuals and social groups to transform social decision-making processes to conduct life with greater control over their circumstances, free of preventable diseases or injuries, to face illness conditions
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	The development of the activity took place in the graduate program in health promotion, in a discipline called Groups and Networks, where teachers from different areas (communication, computer science, history, psychology) and students from different courses (arts, pedagogy, medicine, psychology, physical education, nursing, civil engineering) come together to discuss issues pertinent to health promotion with a focus on constructive learning practice in the community (social groups). The subject is offered every 6 months, and the problems to be discussed in the classroom are brought by the students themselves. In this experience report, the theme of urbanization and health promotion through the eyes of skateboarders was brought up by a student who graduated in arts
Which theories and methodologies are used in the teaching-learning process?	The experience reported discusses the topic of urbanization and health promotion through the eyes of a group of skaters. The methodology used was the problem-solving action applying the community oriented approach
What kinds of forms of assessment are applied, results achieved and challenges faced?	The student responsible for the project must present the results to classmates in the classroom during a conversation. In the case of the report presented, the skaters were also invited to participate in the presentation, but they refused, claiming that the university environment was not a space that they were free to visit. The great challenge of opening the university gate for the community is in fact the lack of identity of the community groups within the university. This lack of identity hinders the flow of ideas between students and members of the community and represents a challenge to be overcome throughout the teaching-learning process of health promotion through community actions
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The teaching-learning model we used was based on the principles of the Brazilian educational philosopher Paulo Freire, who indicated in his liberating learning theory a horizontal teaching method in which everyone teaches and learns. In the case reported, the students experienced the ideas and perceptions of the relationship between urbanism and health promotion through the eyes of a group of skaters and through the development of a participatory project between the academic community (graduate students in health promotion) and the urban community (group of skaters), the teaching of health promotion theories and practices followed the principle of valuing innate knowledge present in communities. The methodological proposal is in line with recognizing community mobilization as key in the process of translating theory into health promotion practice

(continued)

Table 19.7 (continued)

Questions	Take-home messages
What others could learn with your experience? What is localized and what is "generalizable"?	We believe that our experience demonstrates the recognition of a population, normally forgotten and discredited (a group of skaters) as having the decisive knowledge to think about urban space and its relations with health promotion. In this vein, we can suggest that the movement to open university gates to the community can be valuable not only for members of the community but for university students. The development of collaborative projects between students and members of society is decisive for putting health promotion theories into practice. We show that skaters are able to understand the principles of health promotion very clearly and use this knowledge to strengthen their community. Our experience can encourage university professors to include groups of society in their educational practice to debate different theoretical and practical aspects of health promotion

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Chapter 20
Teaching Health Promotion in Aotearoa: A Tangata Whenua and Tangata Tiriti Perspective

Heather Came and Francis Kewene

Contents

Introduction

Health promotion looks different in different corners of the globe informed by history, cultural and political landscapes (Signal & Ratima, 2015). Aotearoa (the land of the long white cloud) is the home of Māori (tangata whenua) who have lived here for thousands of years. Much more, recently tangata tiriti (settler peoples) arrived and attempted to colonise this beautiful land. Te Tiriti o Waitangi was the foundational treaty negotiated between hapū (subtribes) and the British Crown that

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outlined how much power would be shared in this whenua (land) (Berghan et al., 2017). Sadly, the promises made have substantively been unfilled, and ethnic health inequities remain rampant (Waitangi Tribunal, 2019).

Health promotion in Aotearoa is centred around hauora, a holistic notion that balances wairua (spirit), tinana (physical well-being), hinengaro (mental well-being), whānau (connection with people) and te taiao (the environment) (Durie, 1999). It is the foundation on which health promotion teaching practice is thought about, developed and delivered in most of Aotearoa (Health Promotion Forum, 2011).

This chapter is the story of two practitioner-turned academics – tangata whenua (Fran) and tangata tiriti (Heather) – looking back on our journeys in health promotion academic teaching and offering advice and direction to our younger selves. The chapter takes the form of two letters informed by our unique cultural, political standpoint and experience in health promotion and public health.

Fran will kōrero (talk) about her experiences as a Māori health promoter and how this influences her public health teaching practice today. Heather will talk about the transition from social justice activist to health promoter and to activist scholar and what this might mean in the classroom.

We will then highlight the points of difference and convergence in our teaching practice. We encourage new and experienced teachers alike to consider our reflection as a koha (gift/offering) for their practice: a provocation, a wero (challenge) and an invitation to meaningfully engage with the first nations/Indigenous people of the whenua (land) where we teach, practise and nurture the next generation of health promoters.

Fran's Letter to Self

Karakia (Blessing)
Mā te whakapono (By believing and trusting)
Mā te tūmanako (By having faith and hope)
Mā te titiro (By looking and searching)
Mā te whakarongo (By listening and hearing)
Mā te mahitahi (By working and striving together)
Mā te manawanui (By patience and perseverance)
Mā te aroha (By doing this with love and compassion)
Ka taea e au (I can succeed)

Kia ora 'ko au' (Greetings 'me')

Guess what, right now as I write this letter, our whenua (lands), our communities and our whānau (families) are reeling from COIVD19. The upside of this horrific global pandemic is epidemiology is no longer another mysterious "ology" word and the New Zealand public has a better appreciation of what public health actually is and does.

Younger me, you will never believe how far we have come and where I work, where you will work -a university. Who would have thought? Māori girl who first went to university at 24 years of age, worked happily with community as a Māori

health promoter now becomes an academic at one of Aotearoa's top western-based universities.

At university I draw from my experiences as a Māori health promoter to inform my practice as a teacher. It is my uniqueness as a Māori health promoter that I weave into the development, delivery, and evaluation of our programmes along with creating connections with my students and colleagues. The university is an often strange and slightly baffling community. I am unsure if everyone here has the same understanding of working together with a collective purpose as I do?

What I have discovered over time is the importance of knowing who I am, and valuing my knowledge, learnings, expertise and relationships, because these qualities help fill my kete (basket) of knowledge which I bring to the world of academia to make me the teacher I am today. Creating relationships and making connections are foundational to who we are as Māori and as health promoters. Whanaungatanga (relationships) flows through into my teaching practice. I teach whanaungatanga from my first class. Two ways I start this process is beginning with my pepeha (an introduction of one's self that draws on connections to tribal links). My pepeha connects me with my iwi (extended kinship group / tribe), hapū (subtribe) waka (canoe), maunga (mountain), awa (river), and marae (area in front of ancestral meeting house and associated buildings), and tūpuna (ancestors). The other approach I use is poetry. This allows me to map my personal journey creating a deeper and broader connection with all my students, building on the way I introduce myself as Māori. I feel this demonstrates to my students they can use a Māori approach to identify who they are and provide an alternative example of how they can identify themselves, what is important to them, and identify things which can connect them with others. Here is the poem I wrote called *Whakapapa*. It maps my journey from conception to where I am today and why I am an academic.

Whakapapa
Te kore, a space of darkness, of beginnings, of potential

Inside her whare tāngata,[1]
with long slender legs all the way to her blue eyes, sandy hair and Dumbo-esk ears
I grew. Into a world that was neither Māori nor British but was mine.
to be me, an actor, a criminologist, health promoter,
an environmental health scientist, a health protection officer.

Tohu now adorn our whare[2] *walls,*
One BA, One Bachelor of Health Science, One Post graduate Diploma in Public Health,
One Masters degrees
Mine, hung along-side tupuna with chiselled faces, tā moko[3] *reflecting back at me*
the failed dream of wanting to be a doctor,
who would stop,
other 13 year old daughters watch their papa die,

[1] *Tāngata – people*

[2] *Whare – house*

[3] *Tā moko – facial markings*

slowly
from an unnecessary preventable disease,
diabetes.

Te kore, the space I hold now, is filled with potential
to save more than one life,
to impact more than one whānau,[4]
to support more than one community.
This is my Te kore

What I have learnt is it's okay to be afraid and unsure. Lean into the hard stuff, resist the racism of the institution and be you. Keep striving to create a better life for yourself, your children, your whānau and the communities you live and work in. Enjoy the laughter, make those friends (even the ones you are unsure about because they are the ones that will bring you most love and joy) and establish those connections. Fill your basket with as much knowledge as you can as this mātauranga (knowledge) is the foundation for who you will become. Nāku te rourou, nāu te rourou, ka ora ai te iwi (with my food basket, and your food basket, all will prosper).

You will work in government institutions and you will experience tension. You will become the translator and negotiator for implementing and holding tight to Te Tiriti o Waitangi and what was reaffirmed; our right to tino rangatiratanga, sovereignty over our own taonga (treasures) and other unique rights and privileges attributed to all citizens of Aotearoa (Waitangi Tribunal, 2019). In these places, you will have to deliver to the priorities of the government and juggle trying to meet the needs of the community with the needs of the institution. You will find ways to put community first.

There is also joy in your life and it comes with the people you work with inside of these institutions. You will reflect on the time you were part of a Māori team lead by a Māori manager surrounded by a whānau team of other Māori health promoters and nurses. Within this rōpū (group), our Māori tikanga and practice are normal and unquestioned. We are reaching our communities because we are part of our community. Often, it was about ensuring relationships in the community are maintained and that community see how their lives could be improved through our programmes. There was always fun, laughter, long hours and working together. We all understood our roles and responsibilities to one another and our community. We are all in the waka (canoe) together paddling in the same direction (Eketone, 2006).

We were acting on tino rangatiratanga as agreed to in article 2 of te Tiriti o Waitangi. But things change my friend therefore I must warn you that our Māori health promotion whānau will be disbanded and assimilated (Came & Tudor, 2017). This will be a painful and disempowering act by the institution on the mana and expertise of those team members. This too will be an opportunity for learning. You will experience the impacts first hand of forced assimilation and the loss of tino rangatiratanga like your tūpuna before you, but like your tūpuna you will fight to

[4] *Whānau – family*

ensure Māori are holding space within their scope of influence, but it will look differently. Be adaptable and be gentle (on yourself and on those around you).

Reflecting on my practice as a Māori health promoter, I was mandated to prioritise nutrition and physical activity as well as injury prevention. I was hands on, looking for opportunities to work alongside the most influential people in our communities, the mama's and our kaumatua (elders). I worked with mama's and their pepe looking at low-cost healthy meals through hands on cooking activities, which included food safety education. I worked with kaumatua encouraging community to get fit by participating in large events such as a Māori golf tournament. I also got involved in lots of different activities outside of work.

What I am most proud of as a Māori health promoter is the injury prevention initiative targeted at young Māori men to try and reduce the alcohol related harm associated with drinking and driving. We developed a waka ama programme informed from te ao Māori (the Māori world). We built relationships with our community so that this 'Don't drink and drive' campaign would become sustainable. Today the local outrigger waka ama club we worked with still maintain the tikanga; awhi mai-awhi atu (looking after yourself and others), being auahi kore (encouraging becoming smoke free and hosting smokefree events), being drug and alcohol free at least 24 hours before paddling, being an accessible sport (both physically and financially), being about whānau, and having fun while exercising.

I have used karakia (blessing) to start this letter and end this letter, they are our anchors. I call them my mechanism for health and safety as they focus me and the class into working together and to think about what we will do together and the karakia to end the class is about focusing our thoughts on what has occurred between us and releasing them from this moment safely so they can move into the next.

As an indigenous, Māori, māmā, wāhine, and ia (he/she/non binary) I weave my practice through the development of my curriculum right through to how I engage with our students If I have learnt anything during my time as a Māori health promoter turned kaiako (teacher) is the importance of staying connected to community. They keep it real.

Ka aroha ki a koe, 'ko au'.

Fran

Karakia whakamutunga (Blessing to close)
Tūtawa mai i runga (come forth from above)
Tūtawa mai i raro (…below)
Tūtawa mai i roto (…within)
Tūtawa mai i waho (and from)
Kia tau ai (the environment)
Te mauri tū, te mauri ora (vitality and wellbeing)
Ki te katoa (for all)
Haumi e, hui e, tāiki e (strengthened in unity)

Heather's Letter to Self

Kia ora e hoa,

Thanks for the bold choices you made as a young person to fight for social justice that led you into health promotion and being an activist scholar. Thanks for having an open heart, and for consistently listening to stories of injustice. You have surrounded yourself with strong capable people and that has made all the difference in the world. Thanks for committing to honing your craft; you have made an interesting life rich in friends, good food and the satisfaction that comes from having clarity of purpose.

The secrets to being a good teacher (if I am one) are the same as the secrets to being an effective activist and health promoter. It is about relationships, it is about listening, it is about reflecting, taking action and reflecting again. It is about staying grounded, having fun, being dedicated, remember where you are from and what your purpose is on this earth. Always kaupapa (purpose) before ego. This work requires you to remain humble so you can continue to learn and refine your practice. Thanks as always to my comrades particularly those of Taranaki, Te Tai Tokerau and Tūhoe that have invested so much time in my development.

Heather your best work comes from listening to Indigenous counter narratives and then taking action to disrupt the colonial master narratives. Your purpose is to attempt to address institutional racism in the health system (and later in the Academy). This will shape your contributions as a teacher of students and as a trainer of health professionals and other teachers. This is your niche in the teaching world – you are a translator, someone that is steadfastly Tangata Tiriti but remains committed to relationship with Tangata Whenua.

Congratulations on submitting your PhD – wasn't that an epic bicultural scholarly adventure. Just reminding you, you were very lucky to be surrounded by such a strong village during that precious time of intellectual seclusion.

I don't quite know how to say this but you know how health promotion is all about relationships, communities, creativity, wairua (spirituality) and rigor in planning and evaluation; while to be blunt university life will be different from that. The Academy is not what we had hoped its folks from all different disciplines and backgrounds and they seem used to being fiercely independent rather than interdependent. You are not walking into a village you will need to build one and that will take a while as you find your feet. You need to approach this like you are engaging with a new community. Take time to learn their language and customs and become the champion of forms and university systems. You are joining a complex system and institutional knowledge, particularly knowing who to ring when you get stuck is everything. It is critical to maintain friendships outside of academic life.

When you first step into your classroom it will look the same as other classrooms. The difference will be the students; they will literally be from all over the world – places you have never been (and with covid19 places you may never get to go). You need to be really aware of what it means to be Pākehā, what it means to be part of the dominant white culture. You will need to design curriculum and reading

lists that reflects the world of your students not just what you know from 20 years in the field doing health promotion. Your current repertoire of stories just isn't going to cut it. And yes, you will need to learn how to say all of those long foreign names and over time they will become familiar and roll off your tongue.

Your background in sexuality education with teenagers and anti-racism education with health professionals will hold you in good stead. Be confident you know how to open and hold spaces, you know how to structure a lesson plan, make a power-point slide, draw out students and manage diverse views. Remember that as the teacher / lecturer you hold much power and what you say and how you say it matters more than ever before. You are constantly being observed and are role modelling values to the next generation of health promoters in everything you do. You will come to learn there is scarce time in the classroom and it matters who you invite into the classroom and how much care you spend preparing for class.

In the beginning it will take a full day to write one lesson and parts of it will work and other parts not so much. Your work as a teacher will be raw and the students will appreciate your quirkiness, but your charm will only get you so far. You need to stay focused on supporting students navigating the learning outcomes. Tertiary education is no longer free like when you went to university, now families have invested a lot of money sending their loved ones to the university and grades are critically important for many.

Note as a fledgling teacher, student evaluations are very important, and the university uses them to rank how good a teacher you are. It is not fit for purpose and will not capture the complexity and wonder of critical health promotion teaching that explores issues of power, justice and privilege. Your will need to be resilient creative and resourceful to demonstrate to the institution the worth of your teaching.

The good news re developing lesson plans is it gets quicker, and you get better at it. Be the woman that consistently solicits feedback from students. Watch other teachers to see what they do well or what you want to avoid. Think about doing a paper on adult teaching so you can understand what the other teachers are talking about. Knowing about Freire (2000), Lorde (1984), Tuhiwai Smith (2012) will only get you so far. You will need to expand your educational vocabulary – learn some jargon and publish regularly in the teaching and learning space so you have evidence about your teaching. No, a photo of the chocolate cake a student made for you won't carry any weight within the institution.

To be a good at this stuff I think you need to focus on your health promotion values and consistently apply them in the classroom. For me this means taking consideration of the health promotion values of Aotearoa - te Tiriti o Waitangi, human rights, equity, determinants, interdependence, aroha and integrity (Health Promotion Forum, 2011) and championing them inside and outside the classroom.

As an activist scholar and teacher, I try and embrace biculturalism in my everyday teaching practice (Came et al., 2019). This impacts on curriculum design, who makes the course reading list, what is in the assessments, through to how I apply tikanga (cultural protocols) and the learning environment that is co-created. You will see this bicultural practice in how I open each lesson with a mihi (formal greeting) to the students and a karakia (blessing) to clear the way and closing with one

too. Sometimes class will involve poetry, waiata (song), story-telling, or manuhiri (visitors) from outside the university. Sometimes it is about sharing food, other times it is about the pause and sitting in silence together.

Ako (Metge, 2015) is a Māori concept about the active process of being both a learner and teacher. Over the years I have appreciated some rich learnings from my students. Heather, look out for Sukdeep Kaur, she will be one of your first students, she taught you about the magic of the banyan tree, a tree with deep and long roots, and branches that symbolise unity.

On a good day your classroom will be a magical well-resourced cave within the Academy where you can keep people safe and prepare them for the outside world. I wish for you that your students always feel your classroom is like a virtual banyan tree. Your students will need this and you will need this. Always linger after class as this is when the students that need you will reach out. Take your time with them they won't lead with the horror story of that haven't eaten for several days or that there is violence in their home. You are entrusted with their care and this is important. Trust the health promotion process that we both know works. Learning and teaching is holistic and multi-dimensional.

You have some great teachings days ahead. The time you took a class out to the site of an Indigenous occupation and sat around the fire learning the history of the whenua (land). The time the shy Chinese students sang the only song they knew, their national anthem, at the end of class. The time we layout on the grass together and did a nature bath and went swimming at lunchtime on a hot day during a block course. The time there was a power outage and you had to teach in the dark without your trusty power-point slides.

Remember your students are the future of our profession. Never miss a graduation ceremony. It is amazing when you get to meet the parents, partners and children of your students and when then they aren't students anymore they are alumni and colleagues. Then you get to collaborate with them and publish with them in a different way. There is always time for a student-centred selfie and a thank you note, photos of babies years later that tell you what happens next is part of the magic of teaching health promotion.

In solidarity

Heather

The Wero (Challenge) to the Next Generation

As always we acknowledge those who come before us with frameworks of Māori health promotion practice (Durie, 1999; Boulton et al., 2011; Ratima, 2010) which influence our curriculum content and teaching practice.

What we have identified, tangata whenua (Fran) and tangata te tiriti (Heather), when reflecting on our teaching practice is the uniqueness we both possess; our experiences as practitioner-turned academic. Through this process of reflection, we have identified six key principles which ground us both when we teach. For both of us, these principles ensure we remain tika (correct) and pono (true) in our practice health promoter/Māori/activist/academics. These pou (upright posts) which keep us grounded in our academic practice are the following.

Mana Tangata: Leadership

As a leader you are a role model; it matters what you say and what you do. Always do the tika (correct) and ethical thing even when it is hard. Do what needs to be done and decolonise and indigenise the academia whenever you can. Wind back the white unsafe spaces. Hold warm spaces, step into space across the academy, and ensure Māori voices are heard. If you feel alone, network and look for allies. Form a posse.

Whakaute: Respect

Show respect and be mindful to all those you encounter. The academy can be siloed and disempowering for Māori and activist academics. Whakamana (uplift) all those you work with. Remember the words of Maya Angelou – 'I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel'.

Ako: To Learn/To Teach

Always be in a place of life-long learning. Share what you know with humility. Be empathetic. Knowledge is privilege. Being an academic and a teacher is a privilege. Connections and engagement can open the minds of our students. Bring all of yourself to the work. Share freely, openly and with aroha (love).

Whakawhanaungatanga: Manaaki-utu - Reciprocity

Take care your students and share your community with them. Alternatively take your students to community. Maintain and nurture relationships with community carefully. Community will help keep your grounded, relevant. They will always tell you the truth and we are accountable to them. We are interconnected with them.

Pānekeneke: Vulnerability

Take care of yourself and be vulnerable; you are not perfect. It is okay to make mistakes; they become teachable moments. Always reflect on what happens and learn and improve your practice. Students want to meet teachers that are whole, vulnerable, strong and inspirational.

Wairua

Wairua is that element which tethers these principles together weaving them together with our atua me tupuna (our gods and ancestors). Wairua is the connection to that which is more than yourself, that which encompasses you, and your students; the past, present and future; and to ancestors, to land and to the beginning of time. This is the unseen force of spirit. Teaching is wairua work.

We challenge you to establish relationships with Indigenous communities and form alliances with your non-Indigenous colleagues. You may have to be the translator. Surround yourself with strong and capable people and be a leader. Build communities inside and outside of the institutions you work in. Be holistic in your thinking, be reflective, be disruptive and most of all find fun and joy in what you do. Whakamana (uplift) those you work with, and whakamana your students because they are the kaitiaki (guardians) of the generations to come.

Table 20.1 brings our reflection on the six triggering questions suggested by the editors.

Table 20.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion is the central element for all health practitioner foundational training Health promotion is the art and science of applying health promotion values such as equity, social justice and aroha Health promotion is informed by indigenous principles, concepts and worldviews
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	I am an indigenous health promoter (Fran Kewene) who came to the academy and teachers from an indigenous health promotion position weaving my principles and values in to teaching practice. I have been involved in teaching indigenous health for 12 years and 10 years before that working as a public health practitioner in indigenous public health, in total 22 years' experience I formally started working in health promotion in 1993 working for district health boards and non-governmental organisations and transferred to the academy 10 years ago. I am Pākehā and come to this mahi from a background in social justice activism
Which theories and methodologies are used in the teaching-learning process?	Decolonising methodologies; anti-racist praxis; reflective practice; experiential learning, emancipatory practice – Freire, disobedient teaching – Welby Ings
What kinds of forms of assessment are applied, results achieved and challenges faced?	Student attendance and participation; critical and reflective thinking demonstrated through oral presentations; written project plans; reflective journals; community placements; briefing papers; artefacts
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	We teach from all the documents we referenced in our article
What others could learn with your experience? What is localised and what is "generalisable"?	Our work is a challenge to others teaching health promotion internationally. How do we truly work in partnership to reduce inequities? Where is the voice of indigenous peoples and is this partnership? Where is the voice of the marginalised in your frameworks and models? We need to be at the designing, implementing and evaluating our teaching and learning health promotion practice

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Chapter 21
Training and Participatory Research in Health Promotion Courses: Reflections and Contributions for Knowledge and Experiences

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Introduction

Health promotion as advocated by the National Health Promotion Policy (PNPS) in Brazil considers the autonomy and uniqueness of individuals, collectivities, and territories. Its main objective is "to promote equity and the improvement of conditions and living modalities, expanding the potential for individual and collective health and reducing vulnerabilities and health risks from social, economic, political, cultural and environmental determinants" (Brasil, 2014, p.13).

Starting from this premise, we consider that training processes in health promotion for undergraduates, graduate students, and professionals from different disciplines should also involve participants from social movements and community groups. This involvement thus enhances the collective construction of research and action projects, with tools, skills, and abilities to translate health promotion theory, policy, and research into practice (Battel-Kirk et al., 2009; Pinheiro et al., 2015).

A training process, supported by the principles and guidelines of community-based participatory research (CBPR) and fostering the participation of subjects and the community in all stages of the knowledge construction process, proves to be equally potent as a training methodology in health promotion. We understand communities to be specific groups of people and organizations, including from professional, patient/user, and public manager sectors. This set of stakeholders can be considered an ecologically connected system, in which taking account of contexts and cultural knowledge is considered an important partnership practice (Trickett & Beehler, 2013).

In CBPR, all participants are co-authors of decisions with goals to reduce inequities and improve living and health conditions. The CBPR theoretical and methodological framework has had its effectiveness demonstrated in international studies, for example, at the University of New Mexico, Engage for Equity: A Long-Term Study of Community-Based Participatory Research and Community-Engaged Research Practices and Outcomes (Wallerstein et al., 2020). Beyond Engage for Equity, a major new scoping review identified 100 studies of reviews in English of different types of reviews (systematic, narrative, etc.) of community-engaged/CBPR and other participatory research, with 58% of those demonstrating outcomes (Ortiz et al., 2020). Adding other languages would even more show the growth of the field.

Through the experience developed in Brazil, reported here, the importance of a course on CBPR is highlighted for the development of competencies in health promotion, understood as a combination of knowledge, skills, and attitudes, which allows an individual to perform tasks according to identified demands (Battel-Kirk et al., 2009; Pinheiro et al., 2015). In addition to guaranteeing elements of "diagnosis," "planning," and "implementation" in health promotion, participatory research that adopts the process of doing and sharing knowledge with groups and communities creates opportunities for participants to be flexible and permeable actors to produce the necessary changes. These learnings can be transformed into elements of "advocacy," developing "communication" and "leadership" in the process of following CBPR methodologies so that actions can be implemented and evaluated in a

participatory way. Thus, the process of participatory research alone generates empowerment for its participants in the combined act of "teaching-learning-reflecting-acting" and adds value to training in health promotion.

CBPR is designed with the subjects involved, because its members are directly affected by the issues that, according to their understanding and perception, need changes. Here we highlight the contribution of Paulo Freire's thought, which is based on a political-pedagogical vision that is guided by the methodological principles of action-reflection-action, whose main concepts are dialectical union between theory and practice; education as a political act; and valorization of popular knowledge and dialogue as a condition for knowledge, autonomy, and transformational change (Freire, 1991, 1992, 2011). The action-reflection-action process is proposed as a cyclical model, which starts from self-reflection (generating questions) to listening (from the thematic questions and from the analysis of the experience itself), to dialogue (from the group reflection, from the analysis of a selected case or a concrete reality), to action (as part of planning alternatives and solutions to the problem situation), and to synthesis (which presupposes the collective evaluation of alternatives and arguments). These assumptions can support educators to engage in critical dialogue, using multiple methods and strategies. They can, above all, assist in the development of negotiation skills and other necessary skills for the establishment of dialogue between the various actors in relation (Mendes, 2008). By incorporating these philosophical, evaluative, and political assumptions, research makes it possible to establish effective, affective, cultural, and social communication and, consequently, strongly encourage participation.

Participatory research differs from more conventional research since in opening itself to the participation of people from the choice, deepening, and problematization of issues in relation to the object being investigated, and establishing objectives and analyses of these data, it supposes that participants know "that they already have and that it is brought" into the research, which in Freire's terms (1991, 1992) would be the generating themes. As Green et al. (1996) have stated, the greatest contribution of this type of research is in the epistemological and political field, since it proposes to question the positivist academic supremacy when recognizing the partnership between researchers and the community.

The elaboration and sharing take place in coexistence relationships that incite, at the same time, the researcher to collect the knowledge derived from actions which contributes directly to the production of knowledge (Thiollent, 1996). For Borda (1986, p. 46,47), it is about "taking off the mask of neutrality and the disguise of objectivity" and asking the following questions: "What kind of knowledge do we want and need? Who is scientific knowledge for and who will benefit from it?". As an instrument of social transformation, it opposes the adoption of a rigid model of knowledge production that leads to a reductionist and static view of reality (Borda, 1986). Freire (1991) argues that reality is not something static but is built on a dynamic relationship between objectivity and subjectivity.

It is recognized that the phenomenon to be investigated is part of people's daily lives, which has the primacy of discussing it and presenting it according to their historical and cultural references, attributing meanings to it. CBPR also departs

from conventional models because, by providing full participation, it recognizes that the community has its own voice and knowledge and not only behaves toward groups and people but as objects to be observed, studied, and scrutinized by "outside" inward. It demonstrates flexibility and strengthens the role of local actors and their contributions with their knowledge to the processes of partnership and shared power, influencing the change in living and health conditions.

The participation of those involved in all stages of the research – from the definition of objectives to the implementation of actions, per se – does not guarantee that there is, in fact, "spontaneous knowledge directed toward action," unless the dialectical conditions are guaranteed for reflective dialogue and actions represented by researchers and the community (Westphal et al., 1996). This focus on the health field favors an implementation structure that supports participation and equity, which has already been amply proven through many CBPR projects that report impacts on health equity policies, practices, and results (Cargo & Mercer, 2008; Israel et al., 2010; Wells et al., 2013; O'Mara-Eves et al., 2013; Ortiz et al., 2020; Oetzel et al., 2018). Within CBPR, the form of community-engaged research most committed to equity, shared power, and empowerment is the major driver of this approach (Kleba & Wendausen, 2009; Wallerstein et al., 2019), like much of participatory action research that comes from the global south (Borda, 1986). Thus, development of collaborative actions for health promotion practices, based on the principles of popular education and shared power, promotes respect, overcomes prejudices, and reduces hierarchies of power in the search for equity.

Context of the Experience

In 2019, the research group "Multiple Seeds" (Multiples Sementes) was created, which constitutes a collaborative network between the Center of Participatory Research, College of Population Health, University of New Mexico (USA); the School of Public Health of the University of São Paulo; the Federal University of São Paulo; the Federal University of ABC, University of Brasília; the Federal University of Minas Gerais; the Federal University of Ouro Preto; Federal University of Pernambuco; Community University of Chapecó; Pontifical Catholic University of Rio de Janeiro; Federal University of Paraíba; State University of Maringá; State University of Bahia; Federal University of Goiás; and University Estácio of Sá. This group aims to share tools and reflections on CBPR, foster a collaborative network of educators and multipliers and participatory research centers for local development and democratization of knowledge, and expand the training and research network.

In 2020, the course "Participatory Research and Empowerment" was offered simultaneously in five cities: São Paulo/SP, at USP's School of Public Health; in Rio de Janeiro/RJ, at the Pontifical Catholic University of Rio de Janeiro (PUC-Rio), in

Chapecó/SC, at the Health Secretariat of Chapecó; in Recife/PE, at the Federal University of Pernambuco; and in Goiânia/GO, at the Federal University of Goiás. The experience took place in 2021, and an edition will be held in February 2022 on national-level dialogue with health promotion, Freire-based popular education, and interactive and participatory methodologies in a transversal and structuring way. The participants' experiences were necessary inputs for the development of skills, attitudes, and positive feelings in the face of interventions anchored in the theoretical assumptions of CBPR.

This course was an outgrowth of an initiative from Nina Wallerstein, with sponsorship by the Health Promotion Unit of the Pan American Health Organization (PAHO), to launch a course with Latin American colleagues in 1999 on Empowerment, Community Participation and Health Promotion, grounded in the philosophy of Paulo Freire. Its current third revision (co-authored by Wallerstein and Parajon, 2021) has been evolving with much collaboration with Brazilian colleagues. The course is now focused on community-based participatory research and empowerment which takes, as its reference, the experience of the "Engage for Equity: Advancing Community Engaged Partnerships" National Institutes of Health study. Engage for Equity (E2) is a 16-year investigation into what makes CBPR and participatory health research (PHR) effective in reducing health inequities (Wallerstein et al., 2020). Engage for Equity has developed CBPR tools and resources to improve participatory methodologies and to evaluate the results of partnerships between universities and communities. Its scope is the creation and implementation of workshops, training tools, and use of resources to strengthen participatory methodologies in diverse contexts to achieve equity in health through interdisciplinary and intersectoral educational practices, committed to critical learning (Parker et al., 2020). In particular, the workshops are based on the CBPR conceptual model, which is being used internationally for strategic planning, evaluation, organizational learning, and quality improvement of partnerships processes, and outcomes (Wallerstein et al., 2021).

This report concerns the experience of the Rio de Janeiro Nucleus, whose authors acted as facilitators under the supervision of Professor Nina Wallerstein of the University of New Mexico, USA. The participants, coming from different areas of activity and professional training, were constituted as an interdisciplinary work group, composed of members with diverse experiences (medical practitioners, social workers, nurses, leaders, dentists, educators, sociologists, psychologists, nutritionists) who were able to share learnings guided by this training process which also successfully produced capacity for a multiplying effect.

The course procedural and training objectives and activities were intended to integrate opportunities for building empowerment into the participatory research process, to analyze local problems and different forms of power relationships, and to collaboratively build skills in participatory processes, so that they could be applied for transforming power relations toward greater equity in health. The course integrated popular education by Paulo Freire as a foundation for facilitating CBPR processes; supported personal and collective reflection on the roles and positions of

power and privilege of different social actors; worked with instruments and methods to formulate, identify, measure, and make visible outcome indicators from participatory research processes; and supported reflections on and sharing of experiences inherent to the field of health promotion.

The Methodological Path

The course was offered in the form of face-to-face workshops and addressed the following themes: power, individual and community empowerment, and participatory community-based research, oriented toward training in health promotion.

Workshops can be considered methodological tools that are characterized by dialogue between the subjects with the intention of reflecting on the daily life and work. In this way, the problematizing workshops are in harmony because they are open models of training and research, in which reflection is maintained as a guiding principle in the entire study process (Chiesa & Westphal, 1995). Galletti (2004) clarifies the word "workshop," saying that it is a broad term, originating from the Latin *officina*, with different meanings, but encompassing the world of work and has in one of its numerous meanings the place where great transformations take place.

We emphasize that workshops have been widely used in the scope of participatory methodologies and in health promotion in the training processes, pointing to new configurations and uses of the activity. Our intention, when using this strategy to produce data, was to open space to reinvent the encounter between subjects, favoring the processes of creation and production of subjectivities, which could enrich, permanently and dynamically, the exchange of experiences. The workshops allow full integration between theoretical knowledge and practice, as commented by Vieira and Volquind (2002), allowing for reflection in action.

The curricular basis of the course used the CBPR methodological steps created in Engage for Equity, which brings a pedagogy that combines the formal and the experiential and, above all, fosters practical and critical mechanisms for the development of more inclusive training processes in the search for alternative paths to construct health promotion interventions that have a positive impact on improving lives.

Training and Learning Experience

Following the principles of the training process, the "Participatory Research and Empowerment" course was developed in 2020 in 8 modules held in 3 meetings, with 21 participants. Table 21.1 presents the course modules and their objectives.

Table 21.1 Methodological path, course module, and objectives

Module	Purposes
1. Introduction, expectations, and history of the projects	Know the participants Identify participants expectations Discuss definitions of empowerment and CBPR Provide personal and collective reflection, aiming to strengthen the learning environment Share actions or projects developed for reflection during the course
2. Power and empowerment	Reflect on power relations in society Discuss inequality, inequities, and power Provide critical self-reflection on actions and resources in working with the community
3. Paulo Freire's dialogue methodology	Present transformative approaches based on Freire's theoretical framework Understand the code development process to expand listening and dialogue with the community Reflect on power hierarchies and trust building Recognize motivation and community engagement processes
4. Community-based participatory research model	Learn and apply the domains of the CBPR conceptual model Recognize the importance of community collaboration in the design, planning, and execution of projects to achieve health outcomes
5. Partnership indicators	Present different perspectives of evaluation processes Understand community participation throughout the process Reflect on the CBPR approach
6. Participatory assessment with a focus on results	Reflect on the development of participatory evaluation Understand how results and indicators should be part of decision-making Understand that decision-making must meet the needs of the community.
7. Empowerment indicators	Apply the evaluation process by results Develop indicators for projects with the community
8. Systematization of the course and assessment	Reflect on participatory methods used in the course Evaluate participants' experiences and learnings during the course

Source: the authors, 2021

Introduction, Expectations, and History of the Projects

In Module 1, after the presentation of the team and workshop participants, a sheet of paper and 5″ X 7″ cards were distributed so participants could write their course expectations, using the following guidelines: my name is, my course expectations are, participatory action research is, and empowerment is. The cards were posted on a mural, having been grouped by themes to make it easier for everyone to see them. The use of this methodological strategy of mobile visualization called Metaplan (Cordioli, 2001) allowed the participants to express themselves freely, since it facilitates the participatory process in a non-hierarchical way.

Another welcoming dynamics called "biography" allowed the participants to present their life and work trajectories. The intention of this activity was for the group to get to know each other, create bonds, and identify possible partnerships based on common work themes. From then on, the following themes of collective interest were identified to generate four working groups that continued together throughout the formative process of the workshop: work and gender; access to primary health care; mental health; and community empowerment.

A collaborative tool from CBPR, called River of Life (Rio da Vida), makes it possible for researchers to document their projects' context and history, recognizing the route, main milestones, achievements, and barriers. It also allows to review where and how the project started, the status, and what the participants want for the future (Parker et al., 2020; Sanchez-Youngman and Wallerstein, 2018). Participants are encouraged to use symbols that portray the history of the project. This tool used in the workshop provided a reflection on the life journey of the partnership or project, making it possible to create a historical timeline of engagement with communities and partnerships.

As an example, during the training process, the group that chose to work with the theme of gender violence created boats in their River representing women assisted by the project who are victims of violence. They demonstrated the difficulties they experienced with stones in the River, identified as violence, political context, police operation, and other complex daily situations. This graphic representation allowed the group to reflect on the importance of context analysis to guide professional practices around health promotion.

In continuity, a reminder of previous activities was carried out. Participants reported the impact that some dynamics had on them and how they reverberated throughout the formative process, giving rise to a discussion on equity, justice, and power. Also highlighted were the "crossings" of daily life in their different contexts, which do not necessarily reflect who we are nor our potentials and our creativity. In general, we mechanically repeat gestures that make us do our duty. The activities carried out so far have proved to be mobilizing for working with the communities, which should reflect the horizontality of decision-making considering the mutual interests.

Power and Empowerment and Paulo Freire's Dialogue Methodology

In Modules 2 and 3, the discussion of power and empowerment was mediated by a collective activity that aims at power relations. The objective of this activity is to provide an experience that generates reflections on aspects of our society that dynamically influence unequal relations of power, privilege, collaboration, and capacity to dare to propose new rules, as well as to discuss the impact of these issues on their projects. The interactive activity also allows each participant to recognize

in himself and in the other, the conditions that generate inequalities or expand possibilities for reflection on inequities and power, among other related themes. This activity was very potent for the debate about the conditions of power and privilege that are often seen as "natural" and limit our ability to react to unjust rules.

In general, innovative reflection-action tools such as those used in the workshop provide academic and community partners with structured, yet flexible ways of examining their practices and identifying collaborative approaches for greater collective empowerment. Process tools and activities that stimulate our values and commitment to equity and align our work with others who share our vision and ideals contribute to broader project outcomes and reinforce the objectives of the partnership (Parker et al., 2020).

The theoretical questions about power and empowerment have been deepened based on the Freirian framework of "praxis." Reflecting on hierarchies of power is critical to empowerment, and the tools provided opportunities for continued reflection on power and other issues that support sustained participation in commitment and trust. The topic of power was debated in the workshop projects and was central to the discussions. The memory and history of Paulo Freire and his conceptions were presented in a shared way by participants and facilitators, materializing the essence and theoretical coherence of the workshop.

Community-Based Participatory Research Model

In Module 4, the CBPR conceptual model was presented with four domains: context, partnership processes, intervention and research, and results, which is available on the website https://engageforequity.org. In general, each domain includes constructs or themes that enhance communication between the various actors (communities, universities, professionals, and governments); favor the voices of the community within the research; intervene in real local needs with strong participation of those involved; and combine knowledge and social action for change with an impact on social policies and practices. However, the central dimension of CBPR weakly highlights the specific research and data collection method used but more strongly invests on changing the relationship between researchers and subjects involved, so that people become collaborative partners in the investigative processes (Wallerstein & Duran, 2006; Wallerstein & Duran, 2018).

The format proposed by the model was used by the groups as a reference to develop their intervention projects by articulating participatory research principles and values of health promotion. There was a fine line in relation to what is defined as "research" and "action"/"intervention," and for many of the course participants, these themes still deserve further theoretical and methodological deepening. An important aspect presented by participants was the adequacy of the activities carried out to promote health promotion actions, both in the context of scientific research and in the areas of assistance, education, development, and health promotion.

The engagement of the people involved permeates their individual history and their contexts. As a pedagogical support for the discussion of "identity and belonging," a playful activity carried out with a large map of Brazil, using colored tapes, papers, and adhesive tapes, produced affective memories of the places they came from and their life trajectories. Throughout the workshop, the collaborative ambience fostered reciprocity among the members, this aspect being part of the training process in the CBPR methodology, which recognizes the importance of building spaces conducive to reflection and the collective construction of socially relevant projects.

The principles and methodologies of Freirian popular education in Freire were presented in Module 4 as a way of seeing the world. In its pedagogical path, in exercises for coding and decoding "generative themes," participants create scenes and/or objects that lead to the problematization of a given situation. The identified themes are codified, and their contradictions are pointed out and start to gain meaning as these themes are dialogued and contextualized through a critical and social view of the subject discussed (Freire, 1992). Within the scope of the workshop, participants in small groups brought objects or images that represented people's reality and presented them to the larger group. As the codifications were elaborated, the participants made their critical analysis, revealing the hidden contradictions.

To exemplify, we can highlight the coding/decoding exercise of the group that worked on access to primary care as a theme. An urban transport card for the city of Rio de Janeiro was presented as a code and triggers the question: does the card guarantee everyone's access to health? The debate brought as an argument that the transport card is not a guarantee for some people to access to health services, especially for elderly and people with disabilities, nor does it guarantee full circulation in the city.

After a reflective and affective dive that led to individual and collective deepening, the domains of the CBPR conceptual model were resumed, deepening the construction of projects that addressed the themes related to work and gender with women from the favela, reflections on facilitating access to primary health care, mental health from an intersectoral perspective, and ways to involve and strengthen community work.

Partnership Indicators, Participatory Assessment with a Focus on Results, and Empowerment Indicators

In Modules 5–7, participatory assessment, partnership, and empowerment indicators were addressed. In general, it is a challenge to health promotion to define qualitative indicators that can guide and reveal the results obtained from participatory experiences. Evaluative approaches in health promotion policies require innovative and complex strategies, theories, and mechanisms through which actions and programs bring about changes. In each social context, varied methods are required, but,

above all, methodologies need to be consistent with the problems involved. Thus, understanding of meanings, perceptions, and cultural aspects is fundamental for successive approximations to the complex reality. To evaluate is to make a judgment of value, and in this direction, the reflections presented in the workshop pointed out that the evaluation process should not be taken as an end but as a precious opportunity; inclusion of diverse actors in reflections about health promotion interventions, programs, or policies for learning and evaluative capacity building can generate information that supports decision-making (Mendes & Sacardo, 2019).

In carrying out this module, the "Definition of Indicators" activity for project evaluation enabled participants to identify the need for the community to actively participate in all stages of the project to be developed, contributing to planning of activities and to identifying results to be achieved. It also made it possible to discuss the political dimension of the actions. Empowerment and autonomy led to the construction of a new narrative in these groups and implied looking at the approach as something constructed, as "fabric sewn" by several hands. This implies for the researcher/researcher/facilitator a change of paradigm and conscience: what is "their objective" or "their looking" no longer makes sense when what is sought is the recognition of choices and reframing by the whole group. In this Module, the participants had difficulties in identifying and building indicators that would make it possible to measure the process and results of health promotion actions. While more time for skill-building was needed, this area of participatory evaluation still constitutes one of the biggest challenges to the evaluation of participatory practices and health promotion projects.

Systematization of the Course and Assessment

Module 8 at the end of the course brought instruments, systematized roadmaps for content evaluation, methodological strategies, facilitation, involvement, and participation. It should be noted that the evaluation was being carried out throughout the training process, but at this moment we sought to recover the most significant learnings of the group. With different expectations, we highlight that the opportunity to acquire new theoretical and practical learning was pointed out, as well as the possibility of reflecting on professional performance and experiencing the CBPR method.

From our point of view, training in health promotion was strengthened based on the methodological construction favored by the development of content and reflections from using the CBPR model and the overall CBPR approach. The experiential aspect acted as a facilitator of the teaching-learning process to the extent that it made everyone part of their own learning process, expanding repertoires and giving reflective vigor to the development of health promotion skills. Thus, the group of participants demonstrated alignment with the purposes of the course and were open to participatory methodologies in all its stages, showing themselves to be involved and committed to all activities.

Considerations About the Applicability of the Experiment

The group's engagement favored the recognition of the intense and organic connection between research and action and doing **with** the people, between the knowledge built and the transformation generated in the experienced reality. We highlight important aspects of the methodological formative path of the workshop, starting from reflecting from the personal experiences to generate the central themes that, in this way, embodied the process of collective construction.

We highlight the opportunity to use CBPR approaches in order to acquire new theoretical and practical learning, based on the possibility of reflecting on professional performance. Training in health promotion is enhanced by the methodological construction favored by the development of content and reflections arising from this approach. The proposed experiential aspect acted as a facilitator of the teaching process, in that it made everyone subjects and authors of their own learning, expanding repertoires and giving the necessary reflexive vigor to the development of competencies in health promotion.

The activities allowed the participants to "dive in" in their identities and establish connections, building and strengthening care bonds with each other during the training process. This contributed to the construction of new knowledge, about new approaches and practices.

The 2020 edition of the course materialized a methodological path designed by several hands, configuring new tributaries to our Rivers of Life through the meetings provided throughout the preparation and execution of the course. This path was marked by co-creation, dialogue, dynamism, shared values, knowledge built, and affections exchanged between all involved. As a result of this experience, the network of *Multiples Sementes* formed a close-knit group of facilitators throughout the year 2020. Given the context of the pandemic of COVID-19 in the year 2021, this group of facilitators chose to deliver the course remotely at the national level simultaneously, in nine groups from nine regions of Brazil. This new approach of an online synchronous format, with 104 participants, allowed for large group presentations, small group projects, and regional dialogues all on zoom. It configured the potential for reapplication of the CBPR and empowerment course and the methodological approaches, considering the different contexts and subjects, but maintaining the guidelines and principles regarding the purposes of action-reflection-transversal action, as an important strategy for health promotion training.

Our results demonstrate and recommend that this active and participatory methodology can be applied in undergraduate or graduate courses as discipline, short-term courses or intersectoral social programs with the goal of developing theoretical and practical skills for the promotion of healthy and equitable communities.

Table 21.2 displays our reflection on the six triggering questions suggested by the editors.

Table 21.2 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Our group understands health promotion as a set of values that refer to citizenship, development, solidarity, quality of life, democracy, and social participation, which combined with public policy strategies, stimulating community actions and developing skills and institutional partnerships, favors the expansion of people's emancipation and collective empowerment. In this perspective, this set of factors seeks to act actively in the social determinants of health, promoting active and autonomous processes
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	The context referred to in the Participatory Research and empowerment course, from which this experience derives, was designed by national and international higher education institutions. Researchers and health professionals from the following backgrounds participated: Nursing, nutrition, biology, psychology, sociology, pharmacy, physical education, and social work. The course was offered for 3 days, morning and afternoon. It is noteworthy that the organization of the course brings together the organization of the curriculum matrix and its operationalization monthly
Which theories and methodologies are used in the teaching-learning process?	Community-based participatory research (CBPR) seeks to integrate the participation of subjects in all stages of the knowledge construction process. It is guided by the approach of Paulo Freire, which is based on a political-pedagogical vision that is based on the methodological principles of action-reflection. CBPR is designed with the subjects involved, because its members are directly affected by the issues that, according to their understanding and perception, need changes. The workshop, held in 3 days and distributed in eight modules, was based on participatory methodologies and health promotion. It sought to guarantee the "to do with" and activate the ability to operate from the contents generated by cultures and disciplinary, professional, and personal views that conform to the group of participants, including the facilitators themselves
What kind of forms of assessment are applied, results achieved, and challenges faced?	The evaluation process adopted follows the guideline of the teaching-learning methodology and is constructed in a participatory way in different dimensions and stages of the training process. It involves considering evaluation as a strategic process and as part of a sociopolitical action. Also supported is the construction of collective interest as well as the intervention to be developed. The results are collected and analyzed based on the production of relevant information, on a quantitative and qualitative basis, obtained from multiple sources, focusing on the production of flexible information, including dimensions of knowledge, skills, and attitudes present in the training process for health promotion. The methodological approach adopted – Participatory evaluation – Is challenging, as it contemplates a new look at external and normative evaluations that integrate disciplinary degrees, present in the health field. The evaluative conception adopted presupposes the construction of a mentality in which interdisciplinarity, intersectionality, and dialogue with reality in the perspective of change are established as guidelines and visions of professional performance, theoretical and methodological paths adopted, and practices in all stages of the journey

(continued)

Table 21.2 (continued)

Questions	Take-home messages
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	For professionals and people to act and develop health promotion practices that result in strengthening individuals and communities, it is essential to define competencies that consider the complexity of this field. Specifically in relation to the pedagogical approach of the course in question, such competencies have been understood as a combination of knowledge, skills, and attitudes that make it possible to guarantee elements of "diagnosis," "planning," and "implementation" of practices and research. Adopting as a fundamental objective of health promotion, the activation of the power of action means building training initiatives that are strongly supported by values that support the construction of the subjects' autonomy, participation, and promotion of partnerships and the strengthening of subjectification processes, which they can attribute meanings and senses to the lived experiences. The process of training in participatory research also generates empowerment for its participants in the combined act of "teaching-learning-reflecting-acting" and adds even more value to training
What could others learn from your experience? What is localized and what is "generalizable"?	This methodology makes it possible to build new knowledge and propose solutions to problems recognized by the community, through the recognition of its traditional and conventional practices and knowledge. It does not prioritize a hierarchy of knowledge that values only what is produced by the researcher and the academy; on the contrary, it understands that the experiences, knowledge, beliefs, and values brought by the subjects have meanings and reflect the social, cultural, and historical context in which they are inserted. Concepts such as equity, empowerment, and solidarity, among others, are understood within what the actors understand and interpret and are mediated by the researcher, who, far from giving them only theoretical meanings, elaborates them based on what these actors understand as they do them – Being the causes, motivations, aspirations, beliefs, and values. Thus, for each social context, the facts presented and the set of values must be appreciated and incorporated in the solution of the problems faced by these subjects

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Chapter 22
Method and Strategies in Health Promotion Teaching-Learning: Evidence from a Networked Postgraduate Program in Northeast Brazil

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Contents

Introduction

Health-care quality and the necessary alignment with the training of health professionals have been a great challenge for all countries in meeting the commitment to implement policies and actions that achieve the goals of a performance that considers cultural, social, and epidemiological dimensions.

There are multiple causes that interfere in the fulfillment of this challenge, from a global increase in chronic diseases and population aging, to the working

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conditions of health professionals in poorer places, international migration, and even the huge shortage in health production due to the training of health workers (Crisp et al., 2008).

Professional health education has not been able to deal with these challenges, largely due to fragmentation and outdated and static curricula, which affect the practice of health professionals. The necessary alignment of the health professionals' training to overcome the challenges mentioned has been leading scientific discussions and productions that guide policies and actions.

It is necessary to redesign the education of health professionals, taking into account the opportunities for mutual, cooperative, and proactive learning of solutions that consider the interdependence of health care according to the acceleration of knowledge and technology flows (Frenk et al., 2010) and that is oriented to the improvement of living and health conditions both at the individual and collective levels (Rocha, 2016). Furthermore, processes aimed at professional development must be a *continuum*, whether through permanent educational processes or postgraduate training.

Postgraduate courses in Brazil increased by about 25% in the number of programs between 2013 and 2016 (Capes, 2017). This increase stems from the growing search for professional qualification, especially in the health area, in order to meet the current needs of work processes in an effective and resolutive way, from the improvement of knowledge and the reorientation of professional practices (Maciel et al., 2010; Oliveira et al., 2016; Costa et al., 2014). Training initiatives in networked postgraduate programs have been one of the answers to this need.

In 2009, health education, research, and management institutions in Northeastern Brazil, aware of the regional inequities in the Brazilian postgraduate offer, and recognizing the potential social, economic, and cultural impacts of the decentralization of health training, formed a contemporary inter-institutional arrangement, in the format of a network, called the Northeast Family Health Training Network (Renasf). Its mission is to enhance teaching and research in health, with a view to improving the development of health workers, establishing itself with solidity, from actions implied with the strengthening of primary health care (PHC). (Meyer & Dias, 2018). It is known the relevance that a graduate program can bring to a society, whether in economic, social, and cultural aspects. The MPSF (Professional Master's Degree in Family Health) arises from a real demand for qualified health professionals to work in the main operationalization of the Brazilian PHC: the Family Health Strategy (FHS). As this is a network program, with a significant number of people involved, whether master's students, professors, secretaries, or technicians, the impacts can be estimated in large proportions.

Within Renasf's work scope, the Postgraduate Program in Family Health (PPGSF) stands out, offered in five federal states, involving 29 institutions and which have already qualified 400 masters in family health, with 170 in the training process. Professional students from the MPSF are graduates in undergraduate programs in the health area (nursing, medicine, psychology, physical education, social assistance, dentistry, and physiotherapy), recognized in Brazil, and they carry out activities in management or care at the FHS. In addition, it had its proposals for

doctoral theses approved in 2019, by the Coordination for the Improvement of Higher Education Personnel (CAPES), and is in the development phase of its first class. The Professional Master's Degree in Family Health (MPSF), a course with regional coverage, is a pioneer in the stricto sensu professional training modality to work in the unified health system (SUS) and its pedagogical orientation is the recognition of health services as living scenarios that produce knowledge, andragogy, and meaningful learning mediated by active methodologies as inducers of the development of critical-analytical skills. (Nuto et al., 2021).

The MPSF is a process and result of a collective construction and has three research lines that guide the development of technical-scientific products as care technologies: health education, health management and care, and health promotion (Hortale et al., 2015). These lines, in addition to guidance for the development of research and technologies for care and health promotion, are configured as modules of the curriculum that aim to provide the theoretical-methodological bases of these fields of knowledge, in order to be in line with the guiding framework of this postgraduate program, which is to give work its educational principle. Table 22.1 presents a summary of the course proposal.

From this perspective, the purpose of this chapter is to present a networked training experience in Brazilian postgraduate education, focusing on the development of competencies in health promotion through active educational methods and strategies adopted in the teaching and learning process.

For this purpose, Renasf's documentary collection (PDI, APCN, course and module evaluation reports, faculty records, and alumni research) is used as a data source and bibliographic sources to put lenses into the data. Descriptive-explanatory analysis is adopted to narrate the experience and the collective subject discourse analysis (DSC) framework is used to analyze the student experience related to the pedagogical strategy presented in the text.

Table 22.1 Pedagogical proposal of the Professional Master's Degree Program in Family Health – RENASF. Brazil, 2021

Professional Master's Degree Program in Family Health	
Concentration area	Family health
Research lines	Health education, health-care management, and health promotion
Pedagogical principle	Student-centered learning and professional practice
Guiding training references	Andragogy, meaningful learning, competency-based education, and active methodologies
Teaching and learning method	Active methodologies with an emphasis on problem-solving and problem-based learning
Curriculum	11 curriculum components (modules)
Educational strategies	Tutorial groups, case analysis and case problems, guided study, seminars, mini-exhibitions, skills training (simulation, role-playing, observation), community practice, and workshops
Learning assessment	Educational and summative

Theoretical-Methodological Frameworks for Learning and Health Promotion

For the health promotion teaching in the MPSF, an entire process of discussion and construction of the theoretical framework on the topic of health promotion over the years and the importance of this knowledge for the practice of professionals in the Family Health Strategy were considered.

With the Brazilian Health Reform movement throughout the 1980s, the health system entered the twenty-first century organized around health promotion and surveillance (Chiesa et al., 2007). This fact has demanded from the competent bodies a more careful look at the training of health professionals so that they can act in this perspective.

The constant social transformations, such as the globalization process, the economic-financial crisis, and climatic and environmental changes, and their implications in the production of the health-disease-care process require changes in the educational processes, so that they are aligned with the training of professionals able to act on the health of the population, changing it positively. It is at this juncture that the proposal for the RENASF MPSF course was born.

The guiding references of the teaching-learning process in the MPSF are andragogy, meaningful learning, and competency-based education. It values the experience and significant learning in the development of professional skills for teaching and attention in family health. The pedagogical conception of the course is centered on the subject's learning, respecting their autonomy, prior knowledge, and experiences that master's students bring from their experiences.

So, the knowledge starts to be reflected and reworked by the student, to constitute their own knowledge (Vasconcellos, 1992). It is in this education-work relationship and in the understanding of the health system as a health-school system, therefore, as places of learning and transformation of practice, that the MPSF is mainly materialized, recognizing andragogy as an inspiring teaching philosophy, presenting a curriculum oriented towards the development of competencies, with active methodologies as the basis of the teaching-learning process (Meyer & Dias, 2018).

Therefore, active methodologies are adopted to achieve the learning objectives because they are aimed at adults, because of the concrete possibility of participation, and because they value meaningful learning in a contextualized way, requirements that are necessary for the construction of knowledge in a more effective way. Among the active methodologies used in the course, we emphasize the use of problematization-based methodologies. In this perspective, problematization and learning through problems are used to meet the conception expressed in the curriculum (Machado et al., 2015).

The active learning methodologies are mechanisms through which various contents are problematized in order to achieve the proposed objectives, following a particular pedagogical conception, enabling the student to develop skills based on

knowing, doing, and being (Anastasiou & Alves, 2004; Mitre et al., 2008; Souza et al., 2013).

Training for the development of skills transcends technical training, favoring active, critical-reflective approaches, which provide the increase of technical, ethical, political, and social aspects to the training of a professional capable of working in a team and taking into account the social reality (Silva et al., 2016; Fonseca et al., 2014). In this perspective, it was also adopted for the teaching of health promotion the orientation of competences deriving from the international consensus of Core Competencies Framework for Health Promotion (CompHP). In the health promotion field, competences started to be discussed after the Galway Conference, held in Ireland in 2008, in which values, principles, and domains for actions in health promotion were indicated (Dempsey et al., 2011).

Competencies for health promotion serve as a reference to establish professional standards in the health field, ensure the quality of work, select professionals, identify and structure training programs, and guide academic education. The development of skills for health promotion in the training of professionals has been discussed in the international scientific literature as a way to ensure comprehensive, resolute, and quality care (Silva et al., 2015; Tusset et al., 2015; Allegrante et al., 2009).

In this direction, the professional master's degree in Brazil, which began with Ordinance 17/200914, promoted the realization of proposals with an emphasis on training in the world of work. It needs to comply with what was proposed at the Galway Consensus Conference: international collaboration on the development of core competencies for health promotion and health education about the importance of developing competences to work in PHC (Nuto et al., 2021).

The set of *Competences in Health Promotion Project (CompHP)* encompasses values, skills, and knowledge necessary for the practice of health promotion, being organized into 46 competences that fit into nine domains: (1) enabling change, (2) health advocacy, (3) partnership, (4) communication, (5) leadership, (6) diagnosis, (7) planning, (8) implementation, and (9) evaluation and research (Dempsey et al., 2011). With these requirements, a professional competent to carry out actions in health promotion will be the one who develops all the domains contained in CompHP in his/her performance.

Dempsey et al. (2011) advocate that primary care professionals should be expected to possess knowledge, skills, attitudes, and values that meet the expectations and needs of users effectively, efficiently, and appropriately for each circumstance.

A research developed with graduates from three classes of the course obtained high scores in all domains. This may indicate that in the formative process, these dimensions were developed, as well as it indicates that health professionals should adopt a practice focused on health promotion (Nuto et al., 2021).

The Health Promotion Module in the MPSF

The organization of the MPSF curriculum is structured in 11 modules, and the cognitive objectives are operationalized, particularly, through tutorial groups, case studies, directed study, seminars, and mini-exhibitions; skill goals, through skills training (simulation, role play, observation); the attitudinal objectives, with tutorial groups, case studies, simulations, and role plays; and mixed objectives, with team projects, community practices, and workshops (Machado et al., 2015).

In the health promotion module, the knowledge related to the health promotion theme was addressed in order for the master's student to develop his/her activities in the FHS, recognizing the knowledge and practices existing in the territory, families, and individuals, valuing the production of integral care; intersectoriality; participatory management; popular participation; autonomy; community organization; culture; territory; social networks; the complexity of the problems; and the knowledge to give new meaning to the care practices were made visible.

In this module, several educational strategies were adopted to achieve the learning objectives, as shown in Table 22.2.

One of the main strategies used in the MPSF is the tutorial group, which addresses different problems in the daily life of health professionals. The strategy takes place in a group of 6–12 master's students, with a facilitator and a reporter and a problem-situation, which should trigger the initial reflections. Master's students' previous experiences and their knowledge regarding the issue or problem under discussion are raised, as well as the learning needs, so that it is possible to build new knowledge to face similar situations (Fiocruz, 2005; Renasf/Fiocruz, 2012).

The tutorial group follows seven steps in its cycle, guided by problem-based learning (PBL): (1) brief clarification of the meaning of unknown terms or expressions in the problem text; (2) problem definition; (3) problem analysis ("brainstorming"); (4) systematization of the various explanations or propositions present in the

Table 22.2 Structure of the health promotion module, MPSF – RENASF. Brazil, 2021

Health promotion module	
Course workload	45 hours
Competence	Capacity to perform a systematized set of critical-reflexive knowledge in health promotion
Objective	Develop skills from the perspective of health promotion principles
Program content	Historical and conceptual landmarks of health promotion, social determination of health, national policy for health promotion; approaches to health promotion; health promotion in the production of care; competencies for health promotion
Structure/ organization	In-person, dispersal activities (in and with a multidisciplinary team and community)
Pedagogical strategies	Tutorial group, conversation wheel, mini-exhibition, operative group, community practice, directed study, integrated panel
Assessment	Participation and performance in activities carried out, development of skills, and self-assessment

analysis; (5) formulation of questions or learning objectives; (6) individual study; and (7) presentation of the syntheses of the individual study, review, and systematization of the explanations found by the group and problem-solving (Schmidt, 1990 apud Mamed, S 2001).

The dialogue exhibition or mini-exhibition is an educational strategy used when you want to address general themes or to clarify issues worked on in the tutorial group sessions (Renasf/Fiocruz, 2012). The participation of professionals from other institutions who are experts in the topic in question is possible. The directed study aims to deepen individual knowledge on a given theme, from reading, interpretation, and writing. The student must, therefore, produce a synthesis based on this learning.

Another important educational strategy adopted in the MPSF and applied in the health promotion module is the practice in the community, through which it is possible to exercise the planning and conduct of actions within the family health strategy, preferably in the communities where master's students work.

It must be carried out in groups and with the involvement of professionals from the family health team responsible for the territory. In this sense, the team project is configured in a strategy that aims to exercise the elaboration of intervention project proposals and, in this case, with a focus on PS. For the development of the module, some complementary educational strategies are also applied, such as the conversation wheel, the accordion dynamics, the integrated panel, and the experiential activity, which intend to obtain, in the learning process of master's students, either previous knowledge of the learning to be worked on, or to conduct learning synthesis (Fiocruz, 2005; Renasf/Fiocruz, 2012).

Health promotion represents a promising strategy to address the health problems that affect human populations. Based on a broad conception of the health-disease process and its determinants, this strategy proposes the articulation of technical and popular knowledge, and the mobilization of institutional and community resources, public and private, in favor of quality of life (Buss et al., 2020).

It is from this perspective that the topic of health promotion is addressed in the module, considering the historical and conceptual aspects of this field, with an emphasis on the daily policies and practices of the family health strategy. In this chapter, the discussion and collective construction of the HP concept will be highlighted, based on the adaptation of the accordion dynamics (Miranda, 2002). This technique enables an individual and collective expression of the group about prior knowledge on the subject. In the health promotion module of the MPSF, we use dynamics in the opening and closing of activities.

The evaluation of master's students is primarily formative, focusing on the process of developing competence to work in the family health strategy, according to the matrix that guides the curriculum and also includes a summative dimension. For the evaluation of learning in the health promotion module, a process is adopted to ensure alignment between the learning objectives, the methodological teaching strategies, and the respective evaluation instruments developed to monitor the master's learning. This process considers evaluation as part of the training, thus adopting and valuing *feedback* as a resource to produce a reflection on learning.

Next, a pedagogical strategy experienced in the health promotion module is presented, which guides the achievement of the learning objective of apprehending the concept of health promotion in accordance with its values and principles; therefore, the basis for the development of competencies aligned with CompHP.

The Collective Construction of the Health Promotion Concept

The teaching-learning process about the HP concept took place in two stages. In the first stage, right at the beginning of the module, we sought to know the conceptions of master's students about health promotion before the process of building learning on the subject. The class was divided into subgroups in order to retrieve individual previous conceptions about health promotion. For this purpose, a coordinator was elected to conduct the activity in the subgroup. Each subgroup received a sheet of wood paper folded in the shape of an accordion, containing the following expression: "I understand health promotion as…." All members individually expressed their understanding of HP in the folded material, so that the first participant registered and moved to the master's student next door without being able to see its construction, and so on until the round was completed. Then, the coordinator opened the "accordion" (Miranda, 2002) and read all the contributions to be discussed in the subgroup, and from there, a collective concept, which was presented in the class, was elaborated.

The second moment occurred at the end of the module with the purpose of recognizing what was expanded from the perspective of the master's students, regarding the concept of health promotion. Thus, the accordion dynamics was applied again, following the same collective construction procedure. The master's students were able to present, critically analyze, and compare with the previous results. These individual conceptions of the group members obtained in the first and second moment are presented in Figs. 22.1 and 22.2, in "word clouds" elaborated with the WordArt program, as a way to allow the visualization of the registers. The technique of Collective Subject Discourse Analysis (DSC) (Lefevre et al., 2005) was used to analyze the concepts collectively built in both moments. For this, a collective discourse of the master's students was produced, selecting the key expressions, grouping them, and assigning a central idea for each concept. The essence of the records was preserved, so that only repetitions were eliminated.

From the individual and later collective records, it was noticed, already at the first moment, an approximation with the concept of health promotion presented in the Ottawa Charter, namely: "the process of enabling the community to improve their quality of life and health, including greater participation in controlling this process" (Brasil, 2001).

Figure 22.1 illustrates what was expressed by the master's students in the context of the first moment of the module.

It is observed that the term "quality of life" is highlighted in Fig. 22.1, being expressed by all subjects surveyed in the first moment. It is agreed that health promotion proposes a new model of care that seeks the quality of life of individuals,

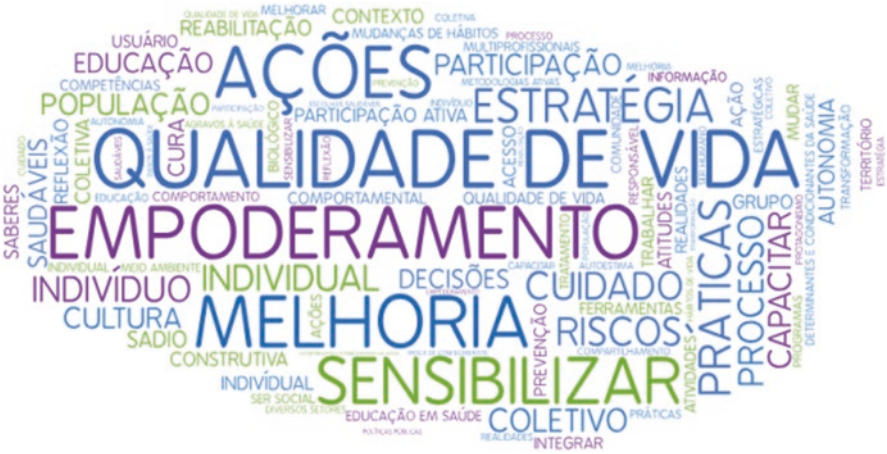

Fig. 22.1 Concept of health promotion expressed by master's students in the first moment of the health promotion module. Brazil, 2021

Fig. 22.2 Concept of health promotion expressed by master's students in the second stage of the health promotion module. Brazil, 2021

under the understanding that health results from socioeconomic, political, cultural, and emotional aspects and not only the biological aspect (Silva et al., 2011).

It is noteworthy that the recognition of the social determinants of health for a professional performance focused on health promotion was evidenced in almost all individual records, as well as the improvement in the quality of life of the

community/population, as the goal of this action/strategy, appear strongly in the discourse of master's students. Therefore, the words "actions" and "improvement" are highlighted in Fig. 22.1.

Thus, it is considered that the understanding of master's students about health promotion was very much directed towards an action, a strategy involving a practice that required professional performance, with regard to awareness, training, and education.

According to the Aurélio dictionary, "sensitize" means "to make sensitive, to soften the heart of; move; tender; make sensitive to a violent emotion, cause commotion" (Ferreira, 2010). It is believed that the sensitization of the subjects involved in an educational process is one of the first steps in this path, intending the necessary opening for change.

On this issue, Westphal (2012) states that actions, even in the field of secondary prevention, should contemplate processes of training and individual and collective empowerment of individuals and groups involved. The idea that subjects need to participate in decision-making processes and be included in actions that motivate collective empowerment is also reinforced. It is believed, therefore, that becoming sensitive to the demands and needs of individuals and the community is configured in an attitude of both individuals and collectives, as well as professionals, fundamental to the incentive of social participation.

Social participation is one of the principles of health promotion that is directly related to strengthening community action, one of the fields of action in health promotion contained in the Ottawa Charter, which, therefore, leads to collective empowerment. The term "empowerment" also in evidence in Fig. 22.1, points again to the recognition of the right and capacity that individuals and communities have to improve their living conditions, from the control over the determinants of health (Westphal, 2012; Brasil, 2001).

It is understood, therefore, that for this level of participation to occur, in addition to being sensitized, it is essential that the population participate in educational processes involving dialogue, problematization of reality, critical reflection, and consequent awareness, so that the relationships of power are considered for social change and transformation.

The education advocated here is aligned to the concept of popular education that guides an "[…] emancipatory educational practice […], directed to the promotion of people's autonomy, the formation of critical consciousness, participatory citizenship and overcoming social inequalities" (Brasil, 2012. p 9).

However, the term "education," which emerged in the speeches, is contextualized in a restrictive way, connecting only to the offering of "information." Health education is recognized as one of the essential strategies for health promotion to the extent that it provides the empowerment of the individual, so that he/she can, if/when/as desired, modify his/her living conditions. In this sense, the simple transmission of information is not enough. For interventions to be successful, they must be planned in order to create opportunities for reflection and not imposition, making the shared knowledge have meaning in different sociocultural contexts (Souza & Pimenta, 2013; Toledo et al., 2011).

Thus, it was noted that the conceptions were focused on transformation, but in a perspective of behavior change, adoption of healthy habits. Terms such as risks, prevention, change of habits, cure, treatment, health problems, and rehabilitation are present in the individual and group records at first and represented in Fig. 22.1. In this same sense, the words protagonism, autonomy, and empowerment seem to be adopted as synonyms in the dimension of self-care, of being co-responsible, of caring for his/her own health.

A reflection is made here regarding individual autonomy, self-administration of risks, responsibility, and self-management, understanding that the conceptions of risk and lifestyle contribute to the idea of making the individual responsible for promoting their own health and of the others, assuming the contours of an economic and moral demand. It is imperative that the victim is not blamed, and that he/she is understood as a subject, considering the whole context, and that the role of the State in favoring healthy environments and choices is not discarded (Akerman, 2015; Gimenes, 2013).

Health professionals, as activators of health promotion actions, should encourage people's critical reflection on the reality in which they are inserted, so that when facing the understanding of the determinants involved in their health-disease process, they can make their care decisions (Beserra et al., 2011). Thus, it is understood the importance of developing the necessary autonomy in the population for conscious decision-making, through the development of personal skills (Buss, 2000).

Therefore, although the word "quality of life" is more prominent in Fig. 22.1, it draws attention to the presence of these terms mentioned above, even if in individual records, paying attention to the different uses and meanings of quality of life (Gimenes, 2013) for the master's students at the first moment.

It is noteworthy that health promotion as a policy appears timidly in the master's students speeches, not being emphasized in the DSC. The importance of the fact that Brazil is one of the few countries that has a national health promotion policy is acknowledged, but the need for its articulation with other public policies is highlighted (Brasil, 2018; Akerman, 2015; Rocha et al., 2014). At the same time, it points to one of the fields contained in the Ottawa Charter, which concerns the construction of healthy public policies, considering that HP goes beyond health care, dealing with political responsibility for health (Brasil, 2001).

Given this understanding, it is considered that in order to promote health, it is essential that good living conditions are ensured to the subjects, because their health does not depend only on individual choices (Oliveira, 2017).

Next, the DSC is presented, elaborated from the concepts expressed by the master's students in the first moment of the module.

An intersectoral theme that integrates various knowledge and develops strategies and interdisciplinary educational actions to sensitize, train, and empower the individual and the community, enabling the subject's protagonism and active social participation in the construction of care and healthier choices in order to reduce risks and injuries and re-signify values and habits. These actions consider the social determinants and conditioning factors of health, working on the behavioral, biological, and social aspects of health from the perspective of improving quality of life (DSC - 1st moment).

It is understood that promoting health is an inherent and necessary action in the context of health; however, the subject needs to be placed at the center of care, as well as of the health promotion policy (Akerman, 2015; Dias et al., 2018), and that not only the minimization or reduction of their vulnerabilities is sought, but that their potential can be considered in the search for empowerment as a means to face precarious conditions (Brasil, 2018; Florêncio, 2018).

In the second moment, the master's students considered the historical context of construction of the concept of health promotion and how it was instituted as a policy.

It is understood that discussing health promotion involves reflecting on the concept of health itself and understanding its reformulations, considering the changes in sociopolitical configurations and the knowledge achieved at each time, as the foundation for policies and actions aimed at the population.

Thus, the WHO definition of health emerges refuting the concept rooted in the biomedical concept of health, defending it as a complete physical, mental, and social well-being (WHO, 1978), reaffirming health from a complex and broader concept. Master's students showed this sensitivity by evoking terms that will be better explored in the text and that denote the complexity, multi-determination of health and sensitive actions and strategies to promote health.

> A concept historically constructed and institutionalized as a policy, constituting a set of political and pedagogical strategies that guide multidisciplinary/interdisciplinary, intersectoral and intrasectoral actions at the individual and collective level, based on social determinants and conditions of health, aimed at reducing inequalities and improving health quality of life. These actions are developed with the active participation of the community, valuing autonomy and empowerment, and co-responsibility, considering respect for the values, singularities, and the historical and cultural context of the subjects involved in this ongoing process, enabling them to give new meaning to life in search of satisfaction and happiness (DSC 2nd moment).

It is evident in the DSC referring to the second moment, the insertion of important terms not used in the first moment as "uniqueness" and "happiness" and the expression "reduction of inequalities." Thus, according to the groups of conceptualizations and approaches discussed by Westphal (2012), the discourse constructed in the second moment approached another concept of health promotion. This concerns a holistic and socio-environmental vision, in which individual and collective actions, as well as political and administrative strategies, are associated with collective empowerment and are aimed at social transformation. In this sense, elements such as the principle of equity and human rights become an ethical imperative.

This understanding comes from the evolution of the concept of health promotion expressed in subsequent documents, such as the Ottawa Charter that outlined the idea of health promotion as the process in which people are trained to act on their health determinants (Feio & Oliveira, 2015).

What was exposed in DSC 2 highlights the social dimension of health and the search to promote the autonomy of subjects in their health-disease processes, so that they obtain a better quality of life (Heidemann et al., 2012).

The expression quality of life remains strong in the discourses of the master's students; however, it is believed that in the first moment the understanding of the term prevailed with the notion of well-being, individual autonomy, and healthy

lifestyle. There is the common sense that the concept of quality of life is polysemic, and that in contemporary times its use has become naturalized and generalized, maintaining an indeterminate meaning (Gimenes, 2013). In the second moment, the relationship between quality of life and personal satisfaction and fulfillment is apprehended, as well as with empowerment, a term that is also presented again, but from a perspective of individual and collective *empowerment*.

In this way, the insertion of new terms in the speeches of master's students is highlighted, indicating the expansion of the previous conceptions presented in the first moment. These are subjectivity, uniqueness, values, subjects, collaborative, sense and meaning, respect, solidarity, desires, and happiness (Fig. 22.2).

It is understood that the studies carried out during the module favored these expanded conceptions, such as the study of the National Health Promotion Policy (PNPS), which addressed the values and principles expressed in the PNPS, considering them as fundamental values for its implementation, namely, subjectivity, solidarity, happiness, ethics, respect for diversity, humanization, co-responsibility, social justice, and social inclusion. Still, this policy adopts principles: equity, social participation, autonomy, empowerment, intersectoriality, sustainability, integrality, and territoriality (Brasil, 2018).

It is evident that the word intersectoriality becomes more expressive in this second moment. Intrasectorial and intersectorial collaboration and articulation constitute one of the important operational axes for implementing health promotion actions, especially with regard to action on health determinants and conditions. It is noteworthy that these intersectorial actions must be planned to establish the responsibility of each sector, but with a sharing of common goals and objectives (Brasil, 2018; Akerman, 2015).

Although it constitutes a broadened conception, it can be observed in Fig. 22.2 and in DSC 2 that themes about sustainability, integrality, and violence did not appear. Thus, although we notice a broader view of HP by master's students, it is noteworthy that terms related to sustainable development or healthy environments and culture of peace, which are cross-cutting themes of the PNPS, were not mentioned. Nor was HP related to health-care networks, one of the operational axes (Brasil, 2018). However, it can be seen that HP becomes conceived as a social movement, an ideology in which the reduction of inequities emerges as one of the goals, with equity being defended, even though it is recognized that there is a gap between discourse and reality (Akerman, 2015).

This perspective found in the study signals an apprehension by the master's students regarding the knowledge presented in the module, which were mediated by the educational strategies adopted for this purpose. This learning is considered as relevant, by understanding that the recognition of these values and principles is fundamental to the development of all health promotion practices (Akerman, 2015).

In this sense, the importance of using educational strategies such as the accordion is indicated for training processes, which allows for a look at the training participants regarding the acquisition of new knowledge presented in the module.

Final Thoughts

The Brazilian Northeast has a successful history of implementing the family health strategy within the scope of primary health care in Brazil. However, this body of knowledge and practices did not reverberate in the production of knowledge in the context of postgraduate studies. The recognition of this social and scientific gap and the already described social, economic, and cultural impact that graduate studies can have corroborated the implementation of this network training experience.

It is believed that the training of masters and doctors in family health/primary care will contribute to the construction of skills and development of the most distinct areas in Brazil where these professionals are assigned. Likewise, it is expected that, in a specific way, the experience can qualify and subsidize the practice of professionals graduating from the course for formative actions in the service and, in a generalized way, can mirror other regions and/or countries to advance in overcoming inequities in training and in the implementation of the expanded perspective of health promotion. Another perspective that can be announced in relation to the generalization of this manuscript refers to the fact that the training experience reported here comes from a networked course, which can inspire other contexts to courses in this format.

In this sense, the experience reported allows us to announce that the MPSF supports regional development and that its graduates and students consider it valuable to bring about changes in the practice of individual care, in the community approach, and in relation to the team and that active educational strategies favor this search. However, there is the challenge of expanding the skills learned to the entire team of workers, of which the master's student is a member.

It is noteworthy, in the illustrative pedagogical strategy, that the monitoring of the process of collective construction of knowledge made it possible to reframe the concept of health promotion, individually and in groups by the master's students, with the results of this process presented in two ways (DSC and word cloud). The adoption of this methodological perspective allowed the analysis of results, avoiding misinterpretations about the real meaning of the text.

Thus, it can be understood that training processes which adopt innovative strategies that promote more meaningful and affective learning make the pedagogical experience lead to more effective results, especially for the knowledge of health promotion.

Therefore, it is considered that this experience can inspire other countries in the formation of collaborative training networks and in the induction of postgraduate health promotion teaching and research, especially those that have work as an educational principle and act in the field of primary health care.

Table 22.3 discusses our reflection on the six triggering questions suggested by the editors.

Table 22.3 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	We acknowledge the variety of conceptions toward health promotion which prevail in each historical cut, and, for many times, orbit it. However, a conception translates values and principles. Through such perspective, we take a stand in the comprehension of health promotion based on Ottawa Charter, and it enlarges for the incorporation of the acknowledgment of the social health determination influence. Therefore, we highlight the necessity of greater community (subjects) participation in the defense of its health and intransigent defense of the state providing an environment and opportunities for healthy choices and confrontation of iniquities (Brasil, 2001; Gimenes, 2013; Rocha et al., 2014; Akerman, 2015) In the exercise of translating the expressed conception for the object of this chapter, we elect the strategies presented in the Ottawa Charter, with an emphasis on the reorientation of health services, based on the proposition of reinventions in the formation of health professionals as strategy for changes in organizations and health services
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	In 2019, educational, research, and management institutions of Brazilian northeast, oriented by convergent goals, built a contemporary interinstitutional arrangement, in a network format, named Northeast Network of Formation in Family Health (Renasf). One of its goals is to contribute for the formation and professional development of Strategy in Family Health (ESF). It has as consolidated action the Professional Master in Family Health (MPSF) (Meyer & Dias, 2018). It is in its fourth group, with an average of 130 vacancies each, with student-professionals of nursing, medicine, psychology, physical education, social assistance, odontology, and physiotherapy MPSF has three research lines: education in health, management and health care, and health promotion (Hortale et al., 2015). They serve as a guide for the development of research and care technology, and health promotion as well, which depict the curriculum modules that indicate the theoretical methodological basis in such fields. The module health promotion happens in 45 days, but it mainstreams all the information
Which theories and methodologies are used in the teaching-learning process?	The principles of the learning-teaching process are based on andragogy, meaningful learning, and education methodology skills. It values the experience and meaningful learning of professional skills for teaching and family health care. The course's pedagogical conception is centered in the subject's education, respecting his autonomy, previous knowledge, and life experiences that the students attending master's degree bring with themselves. It adopted the problematization and learning through problems in order to meet the conception expressed in the curriculum. We consider the curriculum as a social construction embracing content, learning and teaching process, and evaluation. Active methodologies are used for reaching the learning goals, since it has adults as a target, through concrete possibility of participation, valuing the meaningful and contextualized learning – prerequisites needed for a more effective knowledge construction. Among the active methodologies used in the course, we highlight the usage of problem-based methodology

(continued)

Table 22.3 (continued)

Questions	Take-home messages
What kind of forms of assessment are applied, results achieved, and challenges faced?	The learning evaluation happens in a formative and summative perspective, based on the skill development process in health promotion, which is expected for the ones attending master's degree course formation. Their development is evaluated through educational strategies developed, considering their active participation in the activities proposed, frequency, and assiduity. Also, students have the opportunity to make a self-evaluation. The evaluation is continuous during the formative process, making it possible to redirect the learning process through individual and collective feedback. As a result, we emphasize the skill development practices in health promotion with a consequent improvement of skills, which promote health according to the family health strategy frameworks. Such practices are done in a critical and reflexive way aiming at the quality of life improvement
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The learning-teaching plan is founded in a holistic perspective of health and multiple causes of health-disease process guided by values and principles expressed in the National Health Promotion Politics (2018). Acknowledgment of the subjectivity of individuals and collectives and equity principles and social participation are highlighted upon. We conceive health promotion as ethical commitment, considering generosity, happiness, respect for the diversities, justice, and social inclusion. We propose the acknowledgment and development of activities with necessities diagnosis of community/territory, planning, implementation/living and evaluation, through interactive, collaborative, and intra- and intersectoral action, involving partnerships. We are grounded in the socio-environmental approach of health promotion with the development of strategies for empowering individual and collective, contributing to health services redirection. The plan acknowledges skills as synergetic association of knowledge – knowing, making, and being – which make development possible through an excellence pattern. The international consensus of health promotion skills (CompHP) is adopted as a reference
What could others learn with your experience? What is localized and what is "generalizable"?	The experience presented intends to contribute for a reflection and learning in the health professionals' formation field, in order to inspire them for formative processes which consider learning to learn in the professional practice day by day. Thus, we hope that other learning scenarios may be inspired to adopt and experience active methods in the teaching-learning process, generating, this way, knowledge sharing and student's autonomy for an effective learning promotion. It is expected that in a localized way, such experience may qualify egress professional practice for formative actions in the service. In a generalized way, it is intended that it can reframe knowledge in health learning formation. We expect this experience may inspire other formative processes, especially the ones concerning service, such as residency, professional graduate programs, and the performance of primary health-care professionals, consequently

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Chapter 23
Pedagogical Experiences in Teaching and Learning Health Promotion in Undergraduate Education

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Contents

Introduction

This chapter analyzes pedagogical experiences in teaching and learning health promotion (HP) in undergraduate courses, namely, physical education, collective health, nursing, and nutrition, that are offered at public federal universities in Brazil.

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An analytical framework was applied where, in the first phase, each class was analyzed individually based on the following guided questions: How are the HP pillars addressed in HP teaching-learning processes in undergraduate courses? What challenges and potentials can be identified in these experiences? How do these obtained results foresee opportunities for strengthening HP teaching in undergraduate courses? In the second phase, the teaching experiences were looked at as a whole to try and identify how they contribute to translating and applying the pillars of HP.

Analyzing these experiences with teaching and learning HP provide an opportunity to register and systematize practices and identify common aspects that emerge from those pedagogical experiences, which can contribute to international reflections on teaching and learning in the field of HP and its indispensable translation into practices that are in line with HP principles.

Here we would highlight the international movement to build a consensus on the professional competencies and practices of HP. This was spearheaded by the International Union on Health Promotion and Education (IUHPE) and systematized into an accreditation system that is theoretically based on charters and declarations produced at HP global conferences, particularly the Ottawa Charter (WHO, 1986). Also, underpinning this accreditation system is a set of values and ethical principles such as equity and social justice, respect for autonomy, and collaborative and participative ways of working (IUHPE, 2021).

In the Brazilian context, analyses of HP competencies showed that field principles guided the actions of professionals, which is largely in line with the HP competency domains being debated internationally (Tusset et al., 2015). However, these practices were not conducted based on a broad perspective of HP concepts (Tusset et al., 2015). Silva et al. (2018a), who also did research in the context of teaching HP to nurses, found that HP teaching centered on collective/public health classes, but had restricted dialogues with other professional nursing areas. The authors concluded that one of the challenges of teaching HP competencies is associated with overcoming a fragmented logic of adding HP content in specific cases throughout the courses (Silva et al. 2018a).

Silva et al.'s (2018b) analysis is based on the legal framework for developing skills and competencies as described in the Nacional Curricular Guidelines (DCN) established for undergraduate health courses by Brazil's Ministry of Education (Brasil 2001). It is worth highlighting that these documents are currently being revised according to contributions from the National Health Council, which states that the basic element for training health professionals is teaching from a broader perspective of health, where HP and its determinants, permanent health education, and integrated and complementary practices can be powerful instigators for change (Brasil, 2018).

This so-called broader perspective of health, which is the conceptual basis for carrying out and teaching HP in Brazil, was meticulously systematized in the final declaration of the eighth National Health Conference (eighth CNS) held in March 1986 (Brasil, 1986). That conference is a significant milestone in Brazil for understanding health as a social construct determined by broad and interconnected aspects that are clearly represented in the social determinants approach (Buss et al., 2020).

The contributions of the eighth CNS converged with the content described in the Ottawa Charter (WHO, 1986), with HP helping form a conceptual basis for understanding health as a social value.

Furthermore, the Ottawa Charter, an outcome of the first International Health Promotion Conference held in November 1986, describes a set of actions to guide HP practices. These are: build healthy public policies, create supportive environments, strengthen community actions, develop personal skills, and reorient health services (WHO, 1986). In Brazil, the Ottawa Charter's theoretical contributions are related with other national benchmarks in establishing the HP field, such as the final report of the eighth CNS, article 196 of Brazil's federal constitution, the Unified Health System (SUS) Law 8.142/1990 and Law 8.080/1990, and the National Health Promotion Policy – PNPS (Brasil, 2015).

The dialogue between national frameworks and those adopted globally allow us to understand Brazil's broader concept of health, which guided creating and revising the PNPS and which is the basis for the authors' work in HP. Considering health within a broader context implies that it is an outcome of having access to rights and public goods and services, and that social determination, from a critical perspective, reveals the social iniquities that form the main obstacles to HP in the country (Breilh, 2013; Spiegel et al., 2015). This concept of health is also found in the PNPS when it describes its values, guidelines, and principles, which were in the first version published in 2006 as well as in the revised version published in 2014 (Brasil, 2015). Likewise, other nationwide and local policies also used this broader concept and the Ottawa Charter as theoretical bases for action, as in the case of the National Policy on popular health education (Brasil, 2013; Pedrosa, 2021), the State of Goiás Policy for Health Promotion (Goiás, 2019), and the Municipal Policy for Health Promotion in Goiânia (Goiânia, 2020).

In addition to these theoretical bases, it is also worth mentioning that the principles described in the PNPS (Brasil, 2015) and by the WHO (OPS, 1996) were used as pillars for HP teaching-learning actions. Hence, equity, social participation, empowerment, autonomy, humanization, intersectorality, intrasectorality, sustainability, integrity, comprehensiveness, territoriality, holistic concepts, and multistrategic actions are pillars that uphold not only approaches to theoretical concepts but especially the practice of HP classes.

Finally, the teaching-learning processes analyzed here share Paulo Freire's theoretical guidelines for pedagogical practices (Brandão, 2006; Freire, 1987). The teaching-learning process occurs dialogically; founded on horizontal teacher-student relationships, recognition of individual and collective knowledge and experiences, understanding of reality, and critical analysis of existing contradictions; and applied in real-life situations (Freire, 1987). This theoretical and pedagogical reference allows for opportunities to experience participative and dialogical educational interventions directed at developing personal skills, advocacy, community mobilization, co-responsibility, and others (Brandão, 2006, Freire, 1987).

Contextualizing Pedagogical Practices

In this chapter, we analyze five pre-Sars-Cov-2 pedagogical experiences with teaching HP in four undergraduate courses, namely, physical education and collective health at the University of Brasília (UnB), and nursing and nutrition at the Federal University of Goiás (UFG). Table 23.1 shows the general aspects of the classes.

The classes we analyzed were part of undergraduate course curricula that resulted from curriculum reform movements influenced by teaching-learning incentive programs that partnered universities, health services, and civil society. Two programs, the Reorientation of Health Education (Pró-Saúde I and/or II), conducted between 2005 and 2010, and the Educational Program for Health Work (PET-Saúde), conducted since 2007, have been financed by the Ministries of Labor and Health (Dias et al., 2013) to incentivize actions that would solidify HP principles and strategies in the daily activities of the SUS (Frenk et al., 2010).

In addition to teaching-learning experiences in undergraduate health courses, the authors of this chapter are part of a research group called "Promotion and Equity in Health" certified by the National Research Council (CNPq). They are also members of the Health Promotion and Sustainable Development Thematic Group organized by the Brazilian Association of Collective Health (GTPSDS/Abrasco) and are part of intersectoral networks tied to HP public policies. In these capacities, they participate in intersectoral committees associated to school health projects and were involved in revising the PNPS (Alexandre et al., 2016; Rocha et al., 2014), writing key documents about HP with PAHO/Brazil, and elaborating state and municipal HP policies (Lima et al., 2020, Goiânia, 2020, Goiás, 2019).

Table 23.1 Description of health promotion classes analyzed in 2019

Class	Course/duration (years)	Start	Number of students	Year	Subject hours (theory/ practice)
Health promotion	Nursing/5	2005	50	1st	64 hours (32 T/ 32 P)
Health promotion 1	Nutrition/5	2010	36–42	1st	32 hours (16 T/ 16 P)
Health promotion 2	Nutrition/5	2010	36–42	2nd	32 hours (16 T/ 16 P)
Health management and promotion	Collective health/4	2011	25–35	2nd	60 hours (20 T/ 40 P)
Collective health and physical education	Physical education/4	2014	50–55	3rd	60 hours (40 T/ 20 P)

Source: Created by the authors
T theory, *P* practice

Teaching-Learning Health Promotion in an Undergraduate Nursing Course Using the Circle of Health (COH)

The health promotion class description at the UFG Nursing Faculty is in line with national and international perspectives of the HP field. Theoretically and methodologically, the class incorporated content from the process of establishing HP as a practice, public policy, and field of knowledge (Brasil, 1988, 1990a, 1990b, 2015; Macdonald & Bunton, 1992; WHO, 1986).

UFG's Nursing Faculty offers the health promotion class once a year. The theory classes are given using active methodologies and the practical classes use the Paulo Freire method as a reference (Brandão, 2006). In between the different practical scenarios (popular movements, community groups, and school communities), a group of students presents a summary of how the practice works in public schools in the city of Goiânia (the capital of Goiás) and describes the experience of using the Circle of Health (COH) tool (Mitchell & Beattie-Huggan, 2006).

The students are divided into groups and sent out to lead 6th to 9th grade classrooms and conduct three interventions a week. They are required to include the broader concept of health in the content they present and to choose a subject together with the younger students or according to the requests of the school's academic administration (e.g., protection of life, promoting a culture of peace, healthy environment, food and nutrition security, bodily practices). The strategies adopted by the students included: games, team-based learning (TBL), music, photovoice, and skits performed for the class and the school. Each group is responsible for working collectively with the school children to create a presentation that summarizes what they worked on. The final products are then exhibited at the school on the last day, usually as posters, murals, banners, scale models, videos, booklets, etc. Once the classes' practical activities are completed, each group creates a poster depicting their experience and presents it at the Faculty's Scientific Exhibition or to their class.

The COH tool was developed in Canada in 1996 for a variety of activities focused on HP education, planning, implementation, and/or evaluation (Mitchell & Beattie-Huggan, 2006). The COH is formed by five concentric circles connected to each other by a central axis, with a different color for each layer. The way the circles are connected allows the user to move them in clockwise or counterclockwise directions. The circles are organized beginning at the center with the orange circle of holistic health, and then expands outward with the other circles: action strategies listed in Ottawa Charter in yellow, guidelines on the targets of intervention (individual, family, community, system, or society as a whole) in green, identifying the social determinants of health (SDH) in blue, and finally the values that permeate actions and are identified as influencers of collective and individual well-being in purple (Mitchell & Beattie-Huggan, 2006). The tool allows users to define the connections they want to establish in order to elaborate their reflections and formulate a basis for processes of learning, planning, intervention, and evaluation.

The potential this tool offers for teaching HP is that it helps in understanding the broader concept of health and in identifying the possibilities for using the five

Ottawa Charter action strategies in applying social determinants to planning, implementation, and/or evaluation of community practices. The COH contains elements that are similar to those in the PNPS, such as principles and values and the determinants of health, which in the policy appear in the objectives and guidelines and as a transversal theme (Brasil, 2015; Mitchell & Beattie-Huggan, 2006).

In 2017, with the help of master's students studying the COH and how it could be used in planning HP actions in primary health care, we began using the COH as a tool to evaluate students' practical experiences. Most saw the interventions as primarily for developing personal skills from an individual perspective of school performance or promoting personal health practices. They understood that they could have done better at exploring social determinants and reinforcing community actions. They cited intersectorality, participation, and concern for equity as the main principles they adopted in the intervention. The students unanimously agreed that using the COH helped them attain a deeper understanding of the Ottawa Charter.

In 2018, we conducted a workshop for students before their practical experience, where we presented the COH, connecting its components to the theoretical content of the class to support planning the interventions. As a result, one of the practice groups added the COH to their planning and intervention strategies with the intention of addressing violence and promoting a culture of peace. The primary school students had identified bullying, sexism, racism, and homophobia as a problem in the classroom. After debating the broader concept of health, the students worked in small groups using the COH and building different alternatives for confronting one of the problems they had identified collectively.

The following week, each practical group did drama presentations for the primary students on the problem they had addressed. We introduced a large circle, similar to the COH, with all the layers but without the names of the components, to facilitate constructing the problems and how to confront them collectively. The primary students chose to call the circle designated for holistic health "promoting life," which corresponded to their desired outcome. The component of the Ottawa Charter strategies was used to directly present their chosen problems: "bullying, prejudice (sexism, homophobia, racism), and drug use" with the intention of creating a supportive environment in the school community. In the population component, they identified who could help them solve the problem: family, school, health services, and church. The space for health determinants was used to describe strategies: counseling, shelter, listening, dialogue, a support space, and denouncements. Finally, the values they identified were respect, social justice, solidarity, equality, compassion, tolerance, and understanding. The first two values are part of the original COH, and both, along with solidarity, are PNPS values (Brasil, 2015).

At the end of this activity, the younger students presented the Circle to Promote Life to the pedagogical coordinator at the school to show the different ways the school community could address the problems. Having primary students use the COH and (re)build it according to their local needs and nomenclature suggests the potential this tool has for being used in school communities. Furthermore, using the COH helped the undergraduate students achieve greater understanding on how to practically apply the theoretical content of the subject.

Teaching-Learning Health Promotion in an Undergraduate Nutrition Course Using the Cycle of Learning

The nutrition course at the UFG has two required classes called health promotions 1 and 2, offered to first and second year students, respectively. The methodological approach that guides the teaching-learning process in both subjects is the Maguerez Arc (Colombo & Berbel, 2007).

In health promotion 1, the construction of knowledge is mediated by studies on SDH and HP principles and fields of work. This is guided by charters and declarations of global health promotion conferences organized by the WHO (WHO, 2019), as well as by the systematized study of the PNPS (Brasil, 2015), the State of Goiás Policy for Health Promotion – PEPS/GO (Goiás, 2019), and the Municipal Policy for Health Promotion in Goiânia – PMPS (Goiânia, 2020). The practical classes consist of visiting projects and activities related to HP perspectives conducted inside and outside the university by different collectives (NGOs, public institutions, and the third sector). The sites are chosen by the students themselves in dialogue with the professors. These visit experiences are mediated by a mapping instrument that helps understand the projects and activities through the lens of HP principles. The experience is debated in the classroom where students are stimulated to answer questions like: Why is this activity related to the HP field? What HP fields is this experience most associated with? What HP principles can be identified in this action or project? What ideas/suggestions can be sent to the visited site that can contribute to strengthening their work as a space for HP in the city or university? This exercise has proven to be a powerful way of learning the meanings of HP principles based on real cases in two manners. First, because actively looking at activities and projects connected to HP principles requires students to translate and explain each principle in order to obtain better and more complete information on how it is (or is not) seen in the experience. Second, the exercise of thinking through how to make the principles that were not identified in the projects become a reality allows students to contribute to improving the activities. In this process, the Maguerez Arc and its cyclical, reality-based strategy help students understand HP principles based on lived and practical experiences rooted in the real world.

In terms of weak points and challenges, students taking the health promotion 1 class objected that the visits are used only to gain awareness of the activities and that the lack of greater interaction between students and members of the projects prevents closing the cycle of the Arc with applications to reality.

The health promotion 2 class addresses the cycle of planning and interfaces between PNPS, PEPS/GO, and PMPS Goiânia and other equity policies, as well as with Sustainable Development Goals (SDGs) (Rocha & Alexandre Weiss, 2019).

The class's practical experience is conducted at NGOs and third sector or public sector projects in the city of Goiânia. These include a nonprofit entity that offers professional training for underage youth in vulnerable situations, a collective solidarity economy enterprise formed by people undergoing mental health treatment in Psychosocial Care Centers, an NGO that helps children and elderly in vulnerable

situations, public schools, and the internal health commission for federal public servants at UFG. The stages of the Maguerez Arc are applied in five practical experiences associated with five theory activities.

Day 1 – Getting to Know the Situation on the Ground observing the reality of the situation using guided questions created according to the rapid estimate diagnosis technique (Di Villarosa, 1993). The students are stimulated to understand the activities where they will be doing their practical experience, the participation dynamics, the characteristics of the people involved, and the strengths and weaknesses of the practical experience from the point of view of promoting equity and quality of life (objectives of HP policies). Preparation for Day 1 is reading articles in journals or online that describe the characteristics or actions of the practical class location. The students must then present to their class a summary of this first experience and bring up key HP themes. These themes are then theorized in light of academic production and used to establish a plan of action.

Day 2 – Agreeing on a Plan of Action Day 2 focuses on presenting the proposed activity to the people targeted in the practical experience (workers and participants in general) and reaching agreements.

Days 3 and 4 – Application to Reality We call these one of 2 days of practice "D-Days" because it is when the health promotion action is executed, based on the chosen key subject and HP principles. Throughout these practical experiences, we have seen different actions such as a graffiti workshop conducted at a school with the goal of integrating students and teachers, a medicinal garden as an intergenerational activity (elderly and children between 6 and 12), media and digital communication training to strengthen solidarity business sales, a bartering market to encourage conscious consumption and environmental sustainability, social entrepreneurship that empowers youth, body image and self-esteem workshops, healthy eating habits, round table discussions about how to act in situations of harassment, physical activities as tools for socialization, arts and crafts workshops, etc.

Day 5 – Communication Although listed as a specific stage, communication permeates the entire process and is part of the practical classes. Communication is used as a planning tool for the practical experience in dialogues and negotiations between students, between students and professors, and between students and people involved outside the university. We also use communication tools in the process of mobilizing for D-Day, and then we present a final report of the practical experience by way of a poster.

It is important to emphasize that the evaluation and monitoring of this practice is done throughout the experience. Each activity conducted in the field and each outcome are debated back in the classroom and evaluated. The students are stimulated to register outcomes of the different parts of the process (lessons learned, strengths, weaknesses, and solutions), not just the results of D-Day. In this way they learn that evaluations lead to changing and reformulating experiences.

The strong points of this practical experience according to the students and professors of the class is that it brings theory and practice closer together, it provides contact with realities that are different from what is presented in the classroom, it challenges students to translate HP principles into concrete actions, and it helps students learn to work as a group and how to manage time. Along these same lines, the weak points mentioned repeatedly in evaluations were issues related to time management and sharing responsibilities without overburdening individuals.

Finally, the exercise of building knowledge in a participative way that targets promoting equity and health was identified as a gain and opportunity in this HP teaching experience. A broad set of subjects can be addressed from the perspective of HP principles, and with each proposed action or practical experience comes new experiences and new lessons learned. In a reality where teaching is often limited to technical approaches, classes that set out to empower creativity, listening, and seeing the other can help produce workers that are more connected to human hardships and needs, and that at the very least can problematize the economic view of doing health.

Teaching-Learning Health Promotion in an Undergraduate Physical Education Course Using the Team-Based Learning (TBL)

The class description of the collective health and physical education lists the following topics: problematizing Brazil's socio-sanitary reality; social determinants of health; Sustainable Development Goals; health promotion; public health policies and programs; structure and principles of the SUS; planning and evaluation; and training reorientation; and skills development for physical education professionals to work in health promotion. The topic of sports and body practices are interwoven with subjects of society, politics, economy, culture, environment, education, science, ethics, equity, justice, liberty, and health.

The physical education course has a broad interface with the health area in general. This proximity becomes very clear in its core knowledge of epidemiology and the naturalization of discourses about the risks of sedentariness and its relation to chronic diseases. Furthermore, because it is a course founded on nationalist, militarist, biomedical, and capitalist ideologies, it lacks participatory and emancipatory lived experiences (Nogueira & Bosi, 2017). We chose to apply active learning methodologies to HP by way of TBL due to its complexity and its extremely important role in changing the praxis of physical education professionals as agents of promoting individual and collective health.

Because of the lack of previous lived experiences, one class is dedicated to explaining the conceptual foundations, the processes, and the advantages of the TBL method. On that same day, the students are placed into teams that have been previously and intentionally organized by the professor to guarantee as much

representativity as possible in terms of gender, socioeconomic levels, and academic performance. This information is obtained in the beginning of the class by way of a 35-step test (Bahia & Processo, 2016) adapted to the university reality. The test is part of the class's introductory activities and is also used to initiate discussions on subjects such as meritocracy, equity, and social justice.

TBL is, in general, an educational strategy used to develop fundamental skills such as students taking responsibility for their learning acquisition, decision-making, and collaborative teamwork (Parmelee & Hudes, 2012). It is ideal for large classes because it allows the professor to intentionally organize teams of 5–7 students each. TBL has three stages for each module or topic: the student previously prepares for the proposed topic; guaranteed individual and collective preparation in the classroom by way of tests, feedback, the possibility of reviewing any issues, followed by brief explanations by the professor; and the application of the concepts through team assignments that generally involve problem-solving and decision-making followed by presentations and feedback (Bollela et al., 2014).

When the time comes to study HP, students are given 2 weeks to read and study an article by Sícole and Nascimento (2003) entitled, "Health Promotion: concepts, principles, and operationalization." As part of a strategy to motivate the students to study the article, the professor repeatedly emphasizes that the material is the basis for several "cascading" activities, and that failure to study it will impair them on several occasions.

On the day and time scheduled for the test, the students arrive in the classroom and do the individual preparation guarantee test that contains 20 multiple-choice questions and lasts 20 minutes. Then the students separate into teams and do the same test as a group, this time with a time limit of 40 minutes to allow them to discuss questions, answers, and doubts. After that, the test is corrected collectively, with all the teams sharing their answers to each question. They can also ask to review any of the questions or answers the team disagrees on. Finally, the professor gives a brief explanation of the topics that might have generated conflict. The total class time is 1 hour and 50 minutes.

In the next class, the professor begins by trying to dispel any remaining doubts and then explains the next TBL step, which is to practically apply the concepts learned in problem-solving and decision-making. Beginning with the epidemiological problem of contemporary sedentarism and its consequent chronic diseases, the teams are told to choose a program that can promote physical activity or body practices from the perspective of public/collective health.

Teams are given 30 minutes to search the Internet for programs and identify whether there is enough information available, if the program is up and running, and to discuss and decide which initiative they want to investigate. The professor also shares some federal government initiatives (Health in School Program, Healthy Gym Program, Second Half Program, City Sport and Leisure Program) and local Federal District initiatives (Flexibility Program, Block Exercise Programs, Shared Bicycle Program +Bike) that are interesting to the subject. Finally, the programs selected by each team are announced to avoid duplication.

Each team is responsible for collecting information in loco and through available information and for analyzing whether their chosen program and/or initiative includes HP principles. Furthermore, they need to propose changes that would make the program better at promoting health. This stage culminates with written reports and oral presentations that are collectively evaluated by all the teams.

Teaching-Learning Health Promotion in an Undergraduate Collective Health Course: Practical-Theoretical Experience Based on Systematizing Programs and Initiatives

The health management and promotion class has been offered to third year students of the collective health course at the Health Sciences Faculty of UnB since 2011. The collective health program was implemented in 2010 when bachelor's degrees in collective health were being expanded. This was part of a national movement of maturing the field of public health in Brazil and was an innovative step for consolidating SUS in a context of amplifying and complexifying the system (Silva et al. 2018b, Sousa et al., 2015). The curricular organization of the course emphasizes how its content increased in level of complexity as the result of curriculum integration strategies (horizontal and vertical) and active learning methodologies, the most frequently used being the TBL tool and timelines.

The first class consists in mapping out the knowledge and practices of the students and their learning expectations through individual written essays on each one's personal vision or definition of HP. Then, as a group, one or several perspectives are systematized and depicted through an image/drawing or diagrams (graphic representation) on a poster. This recognition of the students' previous knowledge comes from Paulo Freire and serves to strengthen what converged most with current knowledge (evidence-based health promotion) and review any necessary concepts.

Using these early summaries as a starting point, the first block of meetings prioritizes differentiating the concepts of prevention, education, information, communication, and health promotion. To do this, students read articles, conduct directed studies on the trajectory of the field, and identify the main strategic pillars of HP and how they interface with SUS principles and policies from other sectors.

In this same block, each student creates a timeline of how SUS was propagated and institutionalized in Brazil and then as a class they create a mural depicting a collective timeline to be used in debating the main legal and historical benchmarks and resources used in building and revising the PNPS.

In looking at the contemporary context, the students identify the main setting of health promotion in group seminars where knowledge is systematized by watching films, reading articles, and studying the PNPS. Ever since the guidelines of the 2016 Shanghai Charter were recognized, the main transversal PNPS subjects and HP settings have been related to the SDGs (Rocha & Alexandre Weiss, 2019), for example, Equity and Respect for Diversity, SDG 10; Promotion of Healthy Environments and

Territories, SDG 11; Promotion of a Culture of Peace and Human Rights, SDG 16; Promotion of Life at Work, SDG 8; and Promotion of Health in Daily Primary Health Care, SDG 3.

This learning cycle of conceptual, political, and operational aspects of the HP field is finalized with an evaluation by applying TBL as described above in the physical education experience.

The class' second learning block is about practical activities in real service scenarios in government and civil society sectors. The educational goals of this stage are as follows: meet managers and understand management skills related to HP policies, programs, and actions that are ongoing in Brazil and in the Federal District (DF) by visiting these work areas; understand the main HP settings/scenarios by mapping and systematizing policies and programs; recognize the value of identifying systematization and evaluation mechanisms for HP practices; and apply communication strategies and disseminate outcomes in order to give value to and articulate HP initiatives in the DF.

The coordination of the District Policy for Promoting Health in the DF partnered with civil society organization leaders, and UnB graduate students to choose programs and initiatives to be systematized by the students taking the class. The systematization is done in teams of three to four students who interview coordinators and participants; visit work sites; produce written, image, and sound reports; analyze available documents; and research literature review on the subject. The outcomes of this systematization are then presented in dialogue form in class where the "exhibit of health promotion programs and initiatives" includes the participation of representatives from the selected institutions and experts on the subject. The students give their systematization reports to these representatives as feedback on the main results of lessons learned and the applicability of the HP principles found in the initiative. If the group identifies a missing principle or where the work can improve, they should propose solution strategies to help strengthen health promotion in the DF.

One of the main challenges faced by the students trying to systematize local programs and initiatives for this practical experience has been a lack of informative evaluations. This situation was also seen in the study conducted by Medina et al. (2014), who identified that although 100% of the health teams in the DF said they performed HP actions, only 10% had any register of those reported actions.

In 2018 and 2019, respectively, partner institutions asked the students to systematize the experiences and good practices selected for the first District Seminar on Health Promotion organized by the DF Secretariat of Health and civil society collaboration initiatives to bring back and defend the right to the city.

Finally, we understand that the students learned how to apply HP principles using theory and practice. They recognized the importance of resilience and perseverance in advocating for health promotion in a system where care is still predominantly seen from a biological perspective. They also learned the value of registering and systematizing actions in order to later evaluate them.

Messages for Teaching and Learning Health Promotion: Common Points and Challenges

In the second analysis phase of this chapter, the teaching experiences are looked at as a whole to identify the contributions they make to translating HP pillars into concrete teaching-learning actions. While the experiences we analyzed show methodological, conceptual, and practical convergences, they also identify unique aspects that set them apart. These similarities and differences are presented as messages and challenges that can contribute to the debate about teaching HP.

Analyzing the experiences together allows us to highlight that the scenario that instigated creating these classes was part of a process to reshape care with an HP perspective and to strengthen the public health system in a favorable socioeconomic context. As Paulo Freire (2002, p.10) has taught us, "[…] to have powerful change, the education process must establish an organic relationship with the context of the society it is applied to." The federally managed goals of national health and education policies worked together to stimulate these changes in services and in the universities.

The Circle of Health, the Maguerez Arc, and TBL are participative and problematizing strategies that are conducted in action-reflection-action cycles centered on praxis, and thus are in line with the Freire paradigm. The practical sessions of these classes are steered by HP principles, which also guide planning, developing, and systematizing the experiences. An example of this is the commitment to returning the outcomes and evaluations of the practical experiences back to the field, thus creating a broader learning experience that includes partners from outside the class.

Four classes are offered in the beginning of the nursing, nutrition, and collective health undergraduate courses, and in the middle of the physical education course. This allows us to question whether HP learning should be continued throughout the entirety of the courses, and how much opportunity each course offers for continued learning in, for example, other classes and/or practical experiences.

Three of the classes provide lived experiences overseen by workers employed in real-practice scenarios. This allows students to experience the dynamics involved in making agreements and negotiating in the world of work.

Final evaluations are used for all five classes and emphasize applying principles to experiences. This can happen through simulations mediated by videos and social media, as in the case of physical education; or in practical, real scenarios, as in the case of nursing, nutrition, and collective health.

Opportunities to experience intersectoral relations in undergraduate courses were found in four of the five classes in the nursing (school, social movements), nutrition (income generation associations, social assistance), and collective health (civil society initiatives, education, National Industry Confederation, and feminist movement) courses.

The social participation pillar is clear in both the pedagogical approaches and the planning processes of the classes, in partnership with civil society services and organizations. In this perspective, HP is understood as doing *with*, not doing *for*.

In terms of differences in requirements, physical education students observe practices rather than experience real situations, nursing students focus on exercising advocacy, and collective Health students prioritize managing and systematizing programs and initiatives through experiences with managers. Nutrition students focus on fostering HP environments.

The main challenge we identified was that these experiences were conducted only in undergraduate courses and did not implement inter-professionality (Barreto et al., 2018).

The professors face the challenge of not restricting practical training to specific experiences in the first years. As previously pointed out, these classes are taught in the first year of four of the courses, with no other required class offered later on. The professors have invested in adding transversal and longitudinal HP experiences and content throughout the entire academic training of health professionals by offering internships and extension programs in the HP field. The question is: Has the transversal content of these classes, subject to student choices, enabled a continuous HP learning process? We have not been able to answer that question here, but we believe it would be pertinent to conduct future studies on identifying other opportunities these courses offer for continued learning in the HP field.

It is also important to understand the influence of Brazil's current situation of health, political, and economic crises. Since 2016, the national budget for federal universities, science, and technology has been experiencing drastic cuts and social rights are being repressed. This has created obstacles for developing problematizing pedagogical practices founded on rights, overcoming inequality, and promoting equality. At the same time, it has created an even greater need for these kinds of practices.

The COVID-19 pandemic hit Brazil in a period of low social immunity (Nogueira et al., 2020) due to the current administration's fiscal austerity and guidelines. This has led to defunding essential policies like primary care, food and nutritional security, minimum wage, and provisions to incentivize changes to reorient education (INESC 2017).

In addition to affecting university conditions, which now have no financial resources for research and/or extension projects and no work and study provisions, this situation also impacts the practical class experience scenarios because public services are in a state of neglect (incomplete teams, overworked employees, precarious work conditions) (Medina et al., 2020).

Our analysis of HP teaching-learning processes ends at a time when we are adapting to online teaching in a world of pandemics heading towards a new world of what is yet to come. Evidence of growing health iniquities because of COVID-19 (Saboga-Nunes et al., 2020; Van den Broucke, 2020) calls on us professors to resist and to invest even more in teaching HP values, in practical experiences with governance and popular participation, and in developing intersectoral actions in partnerships with government services and civil society initiatives.

Final Considerations

One of the greatest challenges in the field is translating HP principles into coherent practices constructed via processes that enable collective empowerment, which, from the Paulo Freire perspective, is understood as acting together and consciously about real-world problems. Additionally, there are the professional and social ethical commitments that should guide educational actions and the practices of health professionals in order to express a movement that transforms reality.

The experiences we analyzed here rely on theoretical incorporation strategies as guides for reflection and praxis of the classes to reduce the dichotomies and paradoxes between theory and practice that are often found in the realities of health alumni. An example is adopting the social determinants of health approach as an explanatory model for understanding the connections between macro-determinants (such as economic policy) and the multiple levels of HP found among the population. It is possible to identify the impact of fiscal austerity practices on systems of health, education, science, and technology that add obstacles to implementing sustainable HP actions. In this sense, the HP teaching-learning practices presented and analyzed here allow us to identify ways of overcoming these challenges, while also revealing new obstacles.

While such reflections demonstrate the need to further these analyses, they can also contribute to HP teaching-learning processes at different levels of undergraduate studies, as well as support those involved in the challenge of restructuring curriculum matrices. Updating the National Curriculum Guidelines for health courses is debated in Brazil through the movement conducted by the National Health Council and professional health organizations.

Future studies should closely analyze the impact of the COVID-19 pandemic on teaching-learning processes. The classes analyzed in this chapter are currently being taught via telecommuting and the use of digital information technology, which implies developing new learning methodologies and tools. Another point refers to the call sent out by this "new" reality for public health for professional education. The SARS-Cov-2 pandemic reinforces the importance of reformulating the sectoral paradigm adopted for health education into one that is based on intersectorality and multidimensionality and that can build actions that go beyond the health sector and reverse the current context of global sickness.

Finally, the challenges mentioned here emphasize the importance of investing in teaching-learning processes based on advocacy and promoting equity. Acting collectively and equitably can be strengthened by a teaching-services-society partnership, which then strengthens movements that defend the lives and rights of the population in a context of increasing social iniquities.

Table 23.2 discusses our reflection on the six triggering questions suggested by the editors.

Table 23.2 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	We understand health as a social construct determined by broad and interconnected aspects that are clearly represented in the social determinants/determination approach. In this perspective, for us HP is a strategy that proposes the articulation of technical and popular knowledge, the mobilization of institutional and community and public and private resources in favor of quality of life and equity. Consequently, we teach HP as doing *with*, instead of doing *for*
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	We describe five pedagogical experiences with teaching HP in four undergraduate courses, namely, physical education, collective health, nursing, and nutrition, that are offered at public federal universities in Brazil. The classes we analyzed were part of undergraduate course curricula that resulted from curriculum reform movements influenced by teaching-learning incentive programs that partnered universities, health services, and civil society. The classes have been developed each semester from 2005 until now
Which theories and methodologies are used in the teaching-learning process?	The health promotion (HP) teaching-learning experiences analyzed at this chapter adopted historical and theoretical-conceptual aspects of HP and Brazilian health promotion policies and the Ottawa chapter as guiding documents. Paulo Freire's theoretical guideline is used for pedagogical practices. The teaching experiences were based on participatory approaches using different strategies such as team-based learning, the circle of health, and the Charles Maguerez arc. The social participation pillar is clear in both the pedagogical approaches and the planning processes of the classes in partnership with civil society, health services, and government. The practical activities occur in real service scenarios
What kind of forms of assessment are applied, results achieved, and challenges faced?	The HP teaching experiences were evaluated throughout the courses using different participatory methods and strategies. Evaluation strategies are based on in-class activities and in practical community HP interventions. They aimed to create opportunities for students to learn how to translate HP principles into practice. Students acquired skills to plan and implement HP practices using national and international tools and benchmarks. They also had the opportunity to record the results, to systematize the evaluation process, and to communicate it in a HP perspective In problem-based learning (PBL), students worked in small groups aiming to solve a real problem. Evaluation was based on student-led seminars, with staff and student feedback to the presenters Main challenges were as follows: To contribute to greater visibility of HP actions and records in routine of health services; to insert theoretical-practical HP content as a transversal and longitudinal knowledge throughout the academic training of health professionals; and to implement inter-professional classes

(continued)

Table 23.2 (continued)

Questions	Take-home messages
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	Pillars for HP teaching-learning processes – Not only as theoretical concepts but especially in the practices – Were equity, social participation, empowerment, autonomy, humanization, intersectorality, intrasectorality, sustainability, integrity, comprehensiveness, territoriality, holistic concepts, and multistrategic actions. Also, considering that our HP teaching-learning experiences are embedded in Paulo Freire's theoretical guidelines for pedagogical practices, they were opportunities to develop personal skills for collaborative action, advocacy, community mobilization, and co-responsibility. Also, the experiences addressed the five Ottawa charter action strategies and the social determinants of health as approaches to build HP practical experiences and analysis
What could others learn with your experience? What is localized and what is "generalizable"?	Analyzing these pedagogical experiences provided an opportunity to identify and register common aspects that emerged from different courses, such as the relevance of participatory approaches and the articulation of technical and popular knowledge in teaching and learning HP. doing *with*, instead of doing *for*, can contribute to general reflections on teaching and learning in the field of HP and its indispensable translation into practices that are in line with HP principles

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Chapter 24
Using Innovative Curriculum Design and Pedagogy to Create Reflective and Adaptive Health Promotion Practitioners Within the Context of a Master of Public Health Degree

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History of University of Queensland's (UQ) Health Promotion Stream: Developing a Bespoke Health Promotion Suite of Courses

Alignment with Key Competency Frameworks

At the University of Queensland (UQ), health promotion had been a "specialisation" in the Master of Public Health (MPH) since 2011, with the focus predominantly on understanding and intervening on health behaviours. The recommendations from a review of the Master of Public Health (health promotion) programme in 2015 provided impetus for change in health promotion offerings. The recommendations included formulating a clear and distinctive vision for the programme; gaining accreditation both nationally and internationally; implementing structural changes to align with contemporary health promotion with a view to embedding competencies to produce "job ready" graduates; and establishing and strengthening strategic alliances with a view to enhancing student placement opportunities.

In response to these recommendations, the programme was redesigned to meet the competencies of several key health promotion and public health competency frameworks from across the globe, including the Agency for Public Health Education Accreditation (APHEA) (https:www.aphea.be), the International Union for Health Promotion Education (IUHPE) core competencies and professional standards for health promotion education (https:www.iuhpe.org/index/en), and The National Indigenous Public Health Curriculum Framework (Genat et al., 2008) developed by the Public Health Indigenous Leadership in Education network. The changes made were intentional and strategic.

Another influential change occurred within the Australian context when the Australian Health Promotion Association became the National Accrediting Organisation (under IUHPE) for health promotion practitioners. One of the key requirements for becoming an accredited health promotion practitioner is the completion of an accredited health promotion programme, *the MPH (health promotion) programme, which will ensure that UQ increases quality workforce capacity in health promotion.*

UQ's Health Promotion Stream Structured by Health Promotion Cycle and Principles

The Master of Public Health (health promotion) programme was designed to provide students with the theoretical knowledge and practical skills needed to define, critically assess, and promote health. In doing so, we prepare job-ready graduates to engage in and lead a wide range of health promotion endeavours. To achieve these goals and enhance student learning, a suite of three courses was designed to scaffold student learning in a coordinated, developmental way. This programme is distinctive as these courses have been designed to complement each other, support student learning of core knowledge and skills that increase in complexity, and reflect best practice models for health promotion as guided by the IUHPE competency framework (see Fig. 24.1). A "course" corresponds to a discreet educational unit offered over 13 consecutive weeks in partial fulfilment of the Master of Health Program.

These courses reflect contemporary health promotion practice led by holistic, ecological, and salutogenic health promotion principles that not only guide the development of content but also inform pedagogy and assessment so that, in every way, course learnings reflect and model the principles we are trying to embed in students as practitioners. Not only does the programme provide students with solid grounding in health promotion, but it comprehensively covers research skills and critical thinking, which are imperative for effective health promotion practice. These skills are developed in our students through the incorporation of authentic assessment tasks and learning experiences that relate to real-world public health challenges and the everyday work of health promotion practitioners. Specific pedagogical techniques and strategies have been intentionally included to develop and support the creation of thoughtful, evidence-informed health promotion practitioners through critical reflection and the use of authentic assessment participation in real-life health promotion projects and partnerships.

Students undertaking health promotion as a field of study reflect the diversity of our MPH cohort, with a range of disciplinary backgrounds, including medicine, nursing and allied health, psychology, and communication studies. Our programme services both domestic and international students. The numbers enrolled in the MPH Health Promotion programme have doubled from 40 to 80 over the last 5 years.

Fig. 24.1 UQ School of Public Health, Health Promotion Stream

PUBH7034 *Health Promotion in Public Health* provides a strong theoretical and ethical foundation that supports systems thinking required to address broader prerequisites of health over the life course. This course is built around the five action areas of the Ottawa Charter for Health Promotion (1986), and students demonstrate their understanding of mediation, advocacy, and empowerment through assessment design. Students explore various frameworks including socio-ecological and salutogenic approaches that support health and well-being both at local community-based and global contexts. Participatory and community development models of practice are introduced and exemplified through local examples.

PUBH7035 *Health Promotion Planning* is a course where students learn how to locate and critically appraise evidence and demonstrate the purpose and process of a needs assessments to inform the development of health promotion actions. Importantly, it is inclusive of participatory, reflexive, and traditional models of research and practise. Students then develop a detailed plan for a health promotion action based on the evidence in a needs assessment, with consideration given to feasibility and sustainability of the action. In this course students learn the processes, frameworks, and tools that are fundamental in the development and planning of health promotion in practice.

PUBH7036 *Health Promotion Implementation and Evaluation* introduces students to frameworks and tools for all types of evaluation in health promotion. Students will gain the skills to develop comprehensive evaluation plans, guided by the most relevant theory and frameworks (such as Program Logic, RE-AIM) that facilitate the evidence base needed to inform sustainable health promotion actions. Identification of barriers and risks to implementation is discussed and risk mitigation strategies are identified. Figure 24.2 offers a brief description of each course including the main objectives, number of contact hours, and mode of assessment.

The philosophy of the programme is underpinned by an aim to provide students with a blended learning experience, applying theory to practice across this range of vocationally relevant subject areas relevant to public health, producing skilled, experienced, innovative, and employable graduates. Key to the delivery of such a highly valuable learning experience is having access to cross-disciplinary and industry experts to deliver course content and apply examples from practice, creating an authentic learning environment (Herrington et al., 2014). In the courses our industry stakeholders deliver lectures, workshops, and expert panel sessions to integrate academic learning and professional experience into the curriculum to extend student learning and also to demonstrate the cross-disciplinary nature and reality of health promotion. These approaches allow for continuity between classroom, community, and stakeholders and highlight the various communication skills required to negotiate these relationships. Examples are provided in sections "Making Health Promotion Pedagogy Distinct Through Key Concepts That Drive Topics across the Course Suite" and "Course Suite: Distinctive and Transformational Pedagogical Practice".

Course	Objectives	Offering & Delivery	Assessment
PUBH7034 Health Promotion in Public Health	1. Critically evaluate major theories, models, and frameworks in health promotion. 2. Identify and critically appraise the historical and current role of health promotion in public health locally and globally. 3. Analyse the central concepts of health promotion and their place within the broader public health context. 4. Demonstrate an understanding of the importance of communication skills and related educational processes in health promotion 5. Demonstrate an understanding of the broad influences (e.g., social, political, economic) on health and disease prevention for populations and how to apply basic methods in health promotion practice in Australia and internationally 6. Demonstrate effective skills in written communication across various genres. 7. Demonstrate the process and practice of reflection and critical reflexivity	Offered in first year of MPH program Internal and external offering 3 x hours per week; 13 x weeks • Lectures • In-class workshops and demonstrations • Group discussions Guest lectures of "meet the experts"	**Research report:** Use evidence to discuss the role of Health Promotion in responding to a Planetary Health challenge. **Self-reflective blogs**: 1. Advocate, mediate, enable: reflecting on personal social identities; 2. Reflexivity in health promotion practice. **Advocacy letter:** Argue for a call to action about a chosen Planetary Health topic.
PUBH7035 Health Promotion Planning	1. Locate and critically appraise relevant evidence to set priorities for health promotion 2. Demonstrate an understanding of the purpose and process of conducting a needs assessment to inform the development of health promotion actions 3. Evaluate, create, and apply measurement tools for health promotion, and analyse data generated. 4. Synthesise relevant inputs (e.g., theory, evidence, resources) to create recommendations for a health promotion scenario. 5. Create a detailed plan and program logic model for a health promotion action (including meaningful aims and objectives), with an understanding of its feasibility and sustainability 6. Demonstrate skills in written and oral communication in a health promotion context	Offered in first year of MPH program Internal and external offering 3 x hours per week; 13 x weeks • Lectures • In-class workshops and demonstrations • Group discussions Guest lectures of "meet the experts"	**Take home exam:** Understanding health behaviour measures **Needs assessment plan:** Design a needs assessment to address a chosen health topic **Needs assessment report:** Synthesise findings from Needs Assessment **Oral Presentation**: Advocating for a specific health promotion action
PUBH7036 Health Promotion Implementation and Evaluation	1. Critically appraise the evidence on the evaluation of health promotion actions. 2. Identify and apply the most relevant health promotion theories and frameworks to guide health promotion implementation and evaluation. 3. Understand evaluation frameworks and methodology for conducting a health promotion evaluation. 4. Formulate meaningful and realistic objectives to guide a comprehensive evaluation. 5. Construct comprehensive evaluation plans including formative, process, impact, and outcome evaluations. 6. Formulate solutions to overcome challenges in health promotion implementation and evaluation. 7. Understand the process for successful implementation and translation of health promotion actions. 8. Demonstrate effective oral and written communication skills.	Offered in second year of MPH program Internal and external offerings 3 x hours per week; 13 x weeks • Lectures • In-class workshops	**Literature review:** Reviewing and critiquing the methodologies of Health Promotion interventions **Oral presentation:** Develop an evidence-based intervention plan to 'pitch' along with justification for evaluation funding **Evaluation plan:** Design the evaluation plan to accompany the health promotion intervention 'pitched' in Assessment 2.

Fig. 24.2 Overview of UQ's MPH Health Promotion suite of three courses

Making Health Promotion Pedagogy Distinct Trough Key Concepts That Drive Topics Across the Course Suite

Equity and Social Justice in Health Promotion

Recognising the critical role of the social determinants of health, the principles of equity and social justice inform and shape our teaching practice. Social determinants of health reflect factors critical to health and well-being that interact with, but are outside of, the physiological and biological components of health (https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1). These determinants reflect the conditions in which we live, work, and play such as our income, employment, and education as well as housing, food security, water quality, social inclusion, and conflict. Importantly, our approach recognises the co-creation, complexities, fluidity, and the multiple potential stakeholders necessary to ensure health and well-being (von Heimburg & Cluley, 2021). Finally, we position human rights at the centre of understanding well-being for all.

Balance of Participatory and Traditional Methodological Approaches

The guiding concept of health promotion, as outlined by the Ottawa Charter for Health Promotion (1986), is to enable people and communities to increase control over the factors that influence their health, such that they can improve their own health. Given that influencing factors evolve and change with time (e.g., because of changes in health risk, the environment, legislation, or public policy), it is important that methodological approaches used in health promotion evolve with people and communities to ensure their efficacy. To that end, our courses teach students theoretically driven (individual and ecological/community based), evidence-based, and traditional methodological approaches which are balanced with real-world application, through participatory approaches.

Using the Health Promotion Planning Cycle (Naidoo & Wills, 2016) as a guide, students become proficient at identifying the need for health promotion intervention in identified populations. By developing critical thinking, students can appraise the literature (and use the hierarchy of evidence) to determine "what works" (efficacy) in each scenario. Through the use of the ladder of participation (Arnstein, 1969), students consider how to engage with individuals and community to ensure that interventions are implemented effectively.

Focus on Developing Advocacy Skills

Advocacy skills are central to health promotion and a key IUHPE core competency. In our health promotion courses, the role of advocacy has developed over time. In 2018, for PUBH7034, we developed the planetary health report assessment which was followed by a policy brief. In 2019/2020, an advocacy letter assessment replaced the policy brief, and students were invited to send their letter to the relevant ministers and stakeholders. Students were actively engaged in authentic assessment and received constructive responses from government stakeholders on a range of issues from mental health for drought-stricken farming community to home-based waste management systems and even raising awareness in Punjab, India, around the planetary health issue of pesticide poisoning. Knowing that the issues facing people, planet, and health require not only a cultural shift but systemic change (Horton & Lo, 2015), we explored the role of activism through leveraging the Global School Climate Strike in 2019. With the support of the faculty at the School of Public Health, we took part in the strike, allowing the students to exercise their voice in a collective manner in the local community. Through these authentic learning activities and actions, students were given the chance to meaningfully advocate for change, mediate with powerful stakeholders, and be empowered to use their own voice for good in their community.

Research-Informed Teaching and Applied Theory to Practice

Student experience and employability in our courses are enhanced through research-informed teaching (Advance HE, 2017). Indeed, our courses are all delivered by research active staff; many are acknowledged experts in their fields and who are involved in a diverse range of externally funded research, enterprise, and consultancy work. This work has an impact at a local, national, and international level. The activity undertaken by our staff not only informs and refreshes the curriculum but also ensures that students are exposed to contemporary developments in public health. Across PUBH7036, students are exposed to research-led and research-oriented lectures where they are taught research findings, processes, and methodologies from key researchers within public health. Further, we provide research-tutored sessions, where students learn through critique and discussion in face-to-face and online fora.

Transformative Practice Outcomes

Taken together, these pedagogical approaches will support academics, students, and graduates to have transformative outcomes for health promotion. Building from IUHPE's competency framework to think innovatively about the way we teach and do health promotion is key for social justice and health equity. We have also been fortunate to work in a university that is driven to create change, where the student strategy and initiatives support us beyond the classroom. For example, UQ Employability provides guidance to our students about how to showcase the skills they have developed in authentic assessment when they write their curriculum vitae and respond to selection criteria. Figure 24.3 summarizes the evidence-based pedagogical practices supporting transformational learning adopted in UQ's health promotion courses.

Course Suite: Distinctive and Transformational Pedagogical Practice

Modelling Values and Principles of Modern Health Promotion

In our suite of health promotion courses, we explicitly and intentionally model the values and principles of modern health promotion practice (Gregg & O'Hara, 2007) which include holistic, ecological, and salutogenic perspectives and approaches. This is particularly evident in drawing on the principles of engagement with Aboriginal and Torres Strait Islander Peoples as outlined in the National Aboriginal and Torres Strait Islander Health Plan 2013–2023 (Australian Government, 2013)

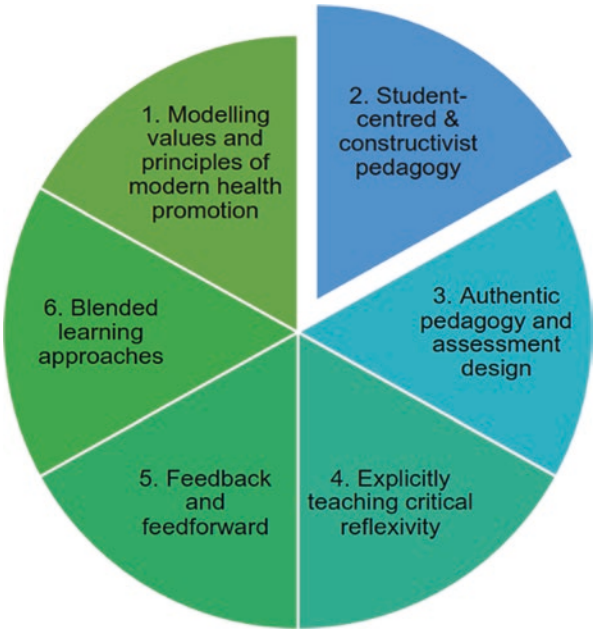

Fig. 24.3 Evidence-based pedagogical practices supporting transformational learning

specifically adopting a strengths-based, partnership/collaborative approach that focuses on health equality and human rights and Aboriginal and Torres Strait Islander peoples' engagement with, and control over, health promotion programmes and activities that involve them (Australian Institute of Health and Welfare, 2013). To this end we strategically aim to model respectful, strengths-based, and inclusive language in all our communication across the suite of courses, e.g. working with people rather working on them; develop initiatives or strategies rather than interventions; and health enhancement rather than obesity prevention. These communication practices include a weekly Acknowledgement of Country that is intentionally personal and invitational to support a culturally safe classroom environment. We foreground health promotion practices of working with First Peoples and linguistically diverse communities and people. We work to prioritise participatory and empowerment paradigms of practice for working with communities in true partnership by honouring Aboriginal and Torres Strait Islander methodologies such as Cultural Social and Emotional Wellbeing framework, forwarded by National Empowerment Project (https://www.nationalempowermentproject.org.au/about-us). Students are exposed to traditional western methods of research used in the health promotion cycle, alongside strength-based approaches such as Asset Based Community Development and Stories of Most Significant Change (https://www.betterevaluation.org/en/plan/approach/most_significant_change).

Embedding Aboriginal and Torres Strait Islander research methodologies is central to providing culturally safe health promotion practice when working in

communities. However, challenges remain. As Dr. Irene Watson (2014), of the Tanganekald, Meintangk Boandik First Nations People and Pro Vice Chancellor Aboriginal Leadership and Strategy at the University of South Australia, writes, the

> difficulties of including Indigenous knowledge should not be underestimated. Ongoing racism, exclusions and the (at best) mixed progress to date suggest that there is significant research and thinking remaining to be done surrounding the "how to" part of the problem. Critical thinking requires us to take our experience of the problem of inclusion as a marker of a political and intellectual landscape in need of rethinking in order to articulate political possibilities beyond those offered by the existing discursive framing of the problem. (p. 518).

Here, Dr. Watson calls for an epistemic shift away from privileging western knowledge practices to teaching traditional western science side by side Aboriginal and Torres Strait Islanders' ways of knowing, being, and doing (Bat et al., 2014). One way our programme does this is by funding and supporting a team-teaching model with Aboriginal and Torres Strait Islander scholars to centre what Georgina Whap (2001) calls "living knowledge" or knowledge that is taught from the perspective of Indigenous standpoints and not just about them (p. 22). This co-teaching practice lends itself to modelling critical reflective teaching classroom practice as concepts are explained from both Indigenous and non-Indigenous standpoints.

Student-Centred and Constructivist Pedagogy

According to Ashford-Rowe, Herrington, and Brown (Ashford-Rowe et al., 2014), higher education has been forced to respond to industry expectations of job-ready graduates and has increasingly turned to constructivist teaching philosophies that not only value knowledge but are "situational and personal" (p. 206) and align more closely with real-world experiences. The modelling of participatory and collaborative practice extends further into our teaching of these courses where we explicitly incorporate a student-centred constructivist pedagogy. For Mayo (2008) this "…views learners as 'architects of knowledge' who formulate their own conceptual frameworks based on their learning histories, life experiences, and potentialities for discovery…[and] in a constructivist model, students internally hypothesize and investigate problems as they discover solutions for themselves" (p. 19). Students in this approach become the co-constructors of knowledge.

To enact this model, we have taken seriously King's (1993) concept of "sage on the stage to guide on the side" approach to teaching and altered our lectures to "lectorial" or workshops and incorporated collaborative teaching styles that privilege students and activity-based learning (PUBH 7034/35/36). We intentionally privilege student voice in a de-centred classroom and draw on teacher/learner, learner/teacher models. Such models leverage the depth and diversity of students and their own lived experiences. This pedagogical approach has been acknowledged as being effective practice in education for many years, particularly since Lingard, Hayes, and Mills (2003) found that connecting learning to student's background knowledge

was one of a variety of strategies that increased academic and social outcomes for students. Many of our students come to their master's studies with existing public health (and other) work experience and knowledge, and we explicitly encourage students to contribute their own personal experiences to the learning process which broadens and enriches the learning for all.

One of the very practical ways we facilitate a safe learning space with our diverse group of students is by positioning ourselves in such a way that we will learn as much from them as they will from us. This teacher as learner, learner as teacher model acts to empower student voice in the classroom to encourage participation and deeper learning through facilitator-led group discussion (Quillinan et al., 2019). It is our practice across our suite of courses to set clear ground rules for discussion and respect for others to help facilitate supportive discussions of often sensitive content topics, such as climate change and sexual health.

Authentic Approaches to Pedagogy and Assessment

Authentic learning is a performance-based measure of learning that mimics real-life scenarios (Mueller, 2003) and has been proven repeatedly in education more broadly to increase engagement, learning outcomes, and transfer of knowledge (Lingard et al., 2003; Wiggins, 1993). The term authentic assessment has been used in the academic literature since the late 1980s (Villarroel et al., 2018) and has changed the view of assessment not only as an audit tool of student learning but a vehicle for student learning (Black & Wiliam, 2010; Earl, 2006). It can fundamentally be understood as "replicat[ing] the tasks and performance standards typically found in the world of work" (Villarroel et al., 2018, p. 840). Authentic assessments have been found to also contribute to graduate employability knowledge and skills, an important metric for universities to validate course content (Ashford-Rowe et al., 2014). Given that there is an external driver from employers for graduates to have gained appropriate work experience and to have developed relevant skills alongside their studies, authentic learning opportunities and assessments provide this, and our stakeholders work with staff to provide real-world experiences and live briefs.

One of the ways we incorporate authentic pedagogy is to bring in current health promotion projects and guest lectures from practitioners in the field to demonstrate course concepts as they are applied in the field. For example, in PUBH7036, we highlight the BeUpstanding project (https://www.beupstanding.com.au/) to demonstrate translation of evidence-based practice to practice-based evidence. We also bring in a panel of practitioners across non-governmental, policy, consultancy, and academic sectors to share with students their insights in evaluation and implementation of health promotion actions and programmes. As educators, we revisit this dialogue as we cover key concepts such as developing partnerships and communication skills and navigating the real-world contexts in health promotion actions, evaluation, and research.

Another strategy to integrate authentic pedagogy is through assessment design. While students learn key frameworks and theories that support health promotion work in the "real" world, assessment is modelled on work students will do in the field. Some examples of authentic assessment include The Advocacy Letter in PUBH7034, Needs Assessment in PUBH7035 and the Evaluation Plan, and Action/Implementation Pitch in PUBH7036. Each of these assessments is supported by modules on how to communicate effectively in written and oral genres, across a variety of audiences, to strengthen action in advocacy, health promotion intervention, and evaluation.

Finally, authentic pedagogy realised in classroom environments is the integration of current topics that become the fabric on which concepts are laid out and explored. In 2021, topic examples include health literacy, vaccine hesitancy, climate change, and sexual health. Woven throughout these topics are discussions through which critical reflection is modelled in class discussion as we reflect on needs of community, different ways of knowing, and the privilege continuum that informs our understanding of health promotion practice.

Explicitly Teaching Critical Reflection

There is little doubt that reflective practice in all professions is considered a desirable quality – developing reflective practitioners in all disciplines and areas is without conjecture (Mann et al., 2009). Despite this, Tretheway, Taylor, and O'Hara (2017) claim the "role that critical reflection can play in supporting critical practice, it is underdeveloped in health promotion" (p. 627). Additionally, the ways and means of developing this skill in students are less clear. Self-reflection is a skill that is not innate and needs to be explicitly taught and practiced (Ryan, 2013). There needs to be time dedicated in curricula to nurture and develop this skill in students, otherwise students tend to reflect superficially, which often results in students simply telling us what they think we want to hear. Therefore, developing skills of deep or critical reflection is of paramount importance in health promotion as it is the basis for challenging assumptions, prejudices, and inequities (Issitt, 2003). For students to "understand…the inextricably social, political, economic, and cultural nature of health and health promotion practice" (Wigginton et al., 2019. p. 75), critical reflexivity is a crucial first step in achieving "health for all" (Ottawa Charter for Health Promotion 1986).

To achieve this quality in our students, we teach students how to critically reflect through progressive assessment structure for culturally safe classroom and safe health promotion practice. Drawing on previous work by our colleagues (Wigginton et al., 2019. p. 75), we utilised Bolam and Chamberlain's (2003) concept "light and dark" reflexivity. According to the model, "light" reflection is guided attention to our own practice, in order to inform "better" practice. "Dark" reflection deepens this attention on the self in practice to consider and challenge existing structures that shape our health promotion practice. Our reflexive praxis and teaching methods

enable students to draw from their own diversity and life experiences to challenge inequities and inequalities inherent in health issues (e.g. via reflective activities in the classroom). Through engaging in self-reflexive practice, students learn to recognise and address inequity by reflecting on both the self in practice and analysing their "underlying assumptions, questioning whose interests they serve, questioning knowledge, how practices shape knowledge" (Bolam & Chamberlain, 2003, p. 217). In this way, students nurture the practice of metacognition and critical judgement of complex health issues and problems.

However, teaching critical reflexivity is challenging, and careful consideration is taken to scaffold critical reflection across assessments. In PUBH7034, students write two short blogs that demonstrate insight into their own positioning, first in relation to health promotion practice and second in relation to their research in planetary health. The second blog functions as a formative assessment that feeds into the final task of the course, the Advocacy Letter. Students apply the practice of reflexivity to this authentic assessment to consider how their research affected their own understanding, subjectivity, and positioning in relation to a planetary health issue in order to write an advocacy letter to effect change in policy or practice. This impact is succinctly captured in an unsolicited student testimonial:

> I think reflexivity is one of (if not the most) valuable things I've taken away from my MPH experience. Of course, basic content is important for public health practice, but the reflexivity exercises that were incorporated into the curriculum allowed me to really retain concepts by thinking about how they relate to me and to consider how – for better or for worse – I bring my own set of experiences and opinions to the table. Ultimately, practicing reflexivity has increased my confidence in voicing my perspective and realizing that my opinion is valid (and probably not as far-fetched as I think).

Critical reflection skills are thus embedded in our suite of courses, beginning in PUBH7034, and carried through understanding strengths-based health needs assessment in PUBH7035, and finally understanding the need to critically reflect on their own growth as learners in health promotion evaluation as part of assessment design in PUBH7036.

Feedback and Feedforward

Closely related to the concepts of authentic pedagogy and assessment is importance of using feedback to inform practice. Using feedback in multiple forms is a key graduate outcome (Winstone et al., 2020) and core professional competency in health promotion. For example, in using information obtained through needs assessments to inform programme planning, students act on feedback gained in programme evaluation to inform future iterations of practice. These are essential skills required by modern-day health promotion practitioners. Winstone and Boud (2020) believe that feedback should serve two purposes – to both check on understanding and to award a grade but additionally to provide useful information that students can use to improve future work. These authors state that "feedback is not about grade

justification but forward-looking information that helps students further develop their work" (p. 3), sometimes referred to as "feedforward" (Conaghan & Lockey, 2009).

While there is consensus and strong evidence of effectiveness (Black & Wiliam, 1998, 2010; Hattie & Timperley, 2007) in the literature of the benefits of feedback that feeds forward to inform future work, there is also evidence that "only 60% of students access it. Even when accessed, many students do not apply the suggestions to future assignments making it, in effect, worthless for students and a waste of valuable time for academics" (Wolstencroft & De Main, 2021, p. 313).

To avoid unacknowledged and unseen feedback, and to effectively force students to engage and use feedback and feedforward, we have designed a series of nested assessments in PUBH7036. The Literature Review feeds into the evaluation plan that supports the student's oral presentation or "pitch" to "executive panel". All three are authentic assessments, and within the design, students are required to reflect on feedback given to develop insight and feedforward this insight and communicate their plan to incorporate their feedback into the next nested assessment. In this way students are invited to be part of the feedback process to extend and take control of their own learning, to make feedback a sustainable and dialogic learning activity (Carless, 2013, p.114). To support their reflective process, students are reminded that formative or "light" reflection engages past action in order to gain insight from it to apply to future practice. This process counts toward 10% of their overall mark for each assessment and is again guided by feedback from the markers.

Blended Learning Approaches

Despite some conjecture over an exact definition, Graham and Allen (2005) define blended learning as "…environments [that] combine face-to-face instruction with technology-mediated instruction" (270). Blended learning is proposed as a solution to enhance student learning and engagement, improve access and flexibility, and address organizational and institutional necessities in higher education (George-Walker & Keeffe, 2010). Notably, a systematic review by Rohwer, Motaze, Rehfuess, and Young (Rohwer et al., 2017) concluded that while blended learning had only modest benefit over face-to-face in teaching evidenced-based health-care knowledge and skills, it had a significant advantage on students' attitudes and behaviours towards course content – improving measures of engagement and perceived relevance/usefulness of the content. This attests to a growing body of literature suggesting that the convenience of blended learning is of undeniable benefit to student engagement and satisfaction (de Jong et al., 2014; Snodgrass, 2011). At UQ, we have been fortunate in that all of the courses in our master's programme have been delivered in on-campus and online modes for many years, ensuring access for those working full-time or across distances.

A Case Study in Innovative Curriculum Development: Planetary Health Written Report (7034)

The planetary health report was developed in response to the International Union for Health Promotion Education (IUHPE) 23rd World Conference on Health Promotion, held in Rotorua, New Zealand, in April 2019. IUPHE's 2019 conference theme and session in Rotorua "Waiora: Promoting Planetary Health and Sustainable Development for All" reflects the dependence of our own health on that of our planet and recognises the major global challenge of balancing ongoing development with environmental stewardship.

Students are required to read the Report of The Rockefeller Foundation- Lancet Commission on Planetary Health (Whitmee et al., 2015) to grasp the complexities of planetary health through a socio-ecological lens (Poland et al., 2011). Pedagogy and assessment design ensures that student learning aligns with the Planetary Health Education Framework (Guzman et al., 2021) (see Fig. 24.4). This alignment is accomplished through the articulation of the critical links between humans, social systems, and natural systems to support transformative change and sustainable development. Both are critical to safeguarding the health of the planet and its inhabitants.

Working within this call to research and action, students use evidence from the literature to define what planetary health is and then apply this definition to a specific planetary health topic area, such as deforestation, urban heat island effect, soil degradation, or biodiversity loss to name a few. Using the Ottawa Charter for Health Promotion (1986) framework as a guide, students discuss the role of health promotion in responding to this planetary health challenge. Eco-social approaches to health promotion (Parkes, Poland, Allison, & Cole et al., 2020) challenges the often fragmented and siloed approach to health promotion by making clear the inextricable linkages between health of planet and human health. Building on the framework of UN Sustainable Goals for Development, students use systems thinking to engage the literature on their topics to make recommendations for health promotion action at local, community, and policy contexts.

In 2019, class and tutorial discussions were also taking place within the context of the unprecedented wildfires along the eastern coast of Australia concurrent with other international deforestation events. This context supported student recognition of "personal, cognitive, social and emotional aspects of their learning" (p. e253). As students reflected on, and in some cases grieved, the environmental disaster unfolding in their contexts, they were empowered through their research to call for change at the policy level in their advocacy letter assessment. Students often speak to deepening connection with natural systems and nature because of their research. One former student reflects:

> Before taking the Introduction to Health Promotion course, I did not own a Planetary Health consciousness. Having completed this course, as a health professional I acknowledge the importance of the interconnection between climate change and human health. Hence, I have developed a passion for planetary health advocacy.

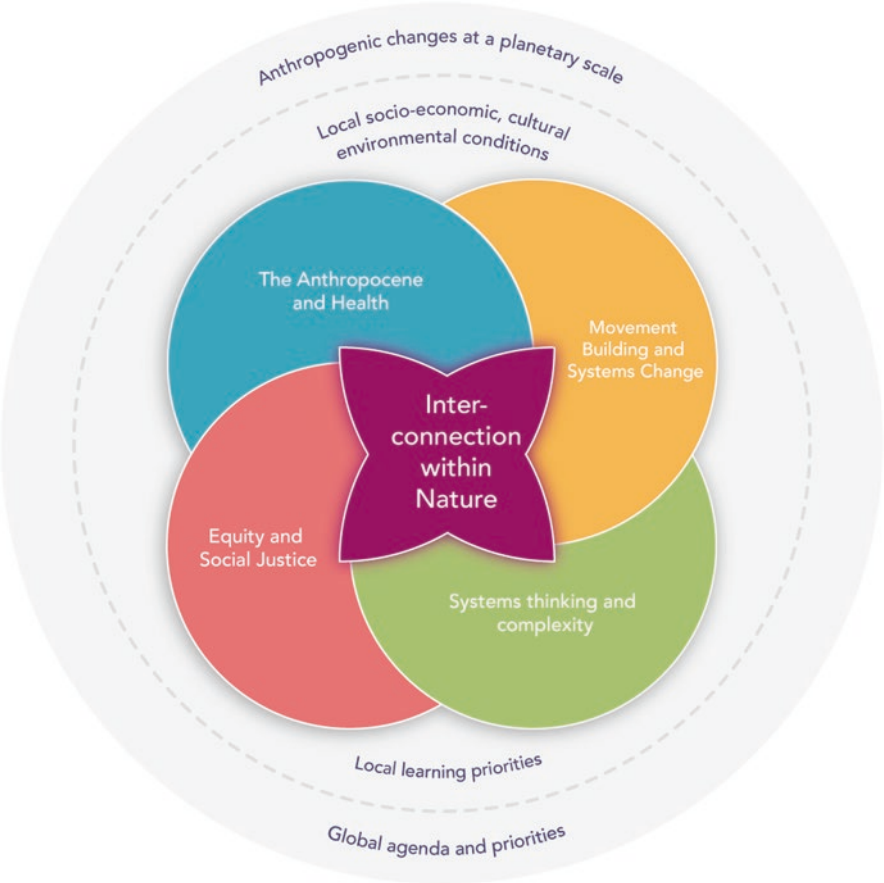

Fig. 24.4 The Planetary Health Education framework (Guzman et al., 2021, p. e253)

In 2020, students were guided by social network analysis (Cullerton et al., 2017) to engage at the local level for positive transformational change. Through engagement with real work contexts, students practice systems thinking and develop communication skills needed to effect change not only for individual health but transformative action at the local (community), national, and global sectors.

This transformative pedagogy is supported by skills in reflexivity that students practice across the course as described above. While students are challenged by these reflexive assessments and by the complexity of planetary health report, students' feedback reflect the value of understanding a systems approach to health promotion. As one student commented in their evaluation of the course, they:

> Learnt so many skills - not just knowledge. . . [the] importance to be able to reflect and reflect well. It is so important to be able to understand health with a planetary approach!

Conclusion

The structure of our MPH programme, the principles that support our curriculum development, and evidence-based teaching and learning strategies shape the development of reflective and adaptive health promotion graduates. Further, the programme reflects the holistic approach to the health promotion education that is invoked by IUHPE's core competencies (see Figs. 24.3 and 24.5) to develop job-ready graduates to lead in global contexts to effect positive change. Through authentic assessments, students build skills to **lead** in industry by applying evidence-based practice to their work contexts. Transformative pedagogy that models and explicitly teaches critical reflexivity supports *ethical values* of health promotion in all contexts from community-based practice through developing health in all policies. Further, creating safe learning environments builds *cultural awareness* in our approach to health promotion, while embedding Aboriginal and Torres Strait Islander methods of research and practice enables the development of culturally safe health practitioners. *Blended learning* offers flexibility for students to improve access and engagement with course content, while inviting health researchers to deliver examples of core concepts strengthens *stakeholder engagement*. In these

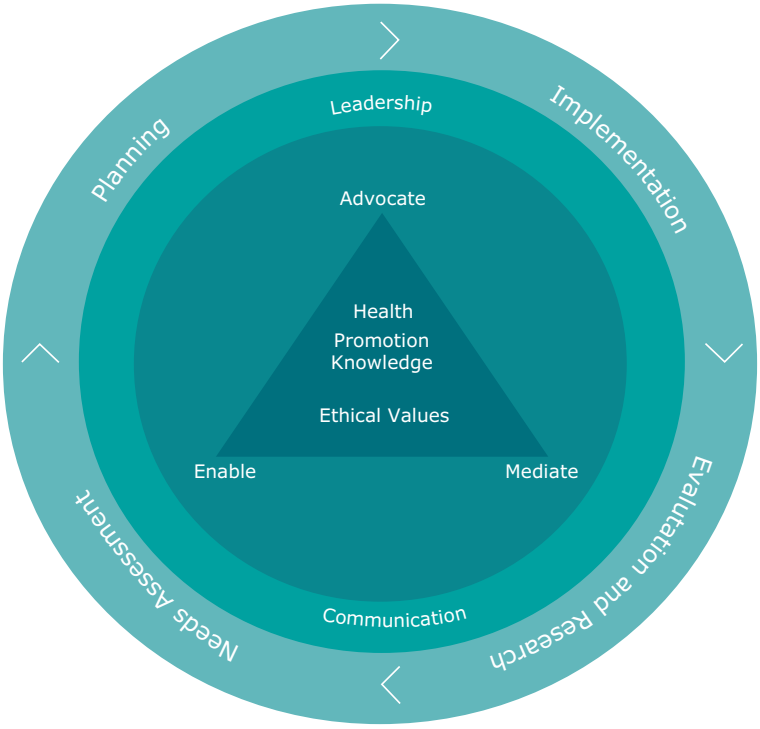

Fig. 24.5 IUHPE Core Competencies for Health Promotion (https://www.iuhpe.org/images/JC-Accreditation/Core_Competencies_Standards_linkE.pdf)

ways the health promotion classroom can empower students to apply core concepts and develop employability throughout the programme.

Our experience in developing the health promotion suite of courses is shaped by our Australian context, both its history and the present moment. We serve a remarkably diverse cohort with students from around the globe, as well as diversity in our Australian cohort, including Aboriginal and Torres Strait Islander students. Unfortunately, colonisation is experienced in communities across the world, and so the learnings we share from our experience can inform educators that seek to decolonise their curriculum through *critical reflexive pedagogy* and embedding First Peoples' knowledge into the courses we teach.

We believe that strong theoretical foundations that support practical application of health promotion action are essential for successful and adaptable graduates to lead in a variety of health promotion contexts. While the Ottawa Charter was codified in 1986, its principles are still applicable to a changing world when they are examined critically through the lens of health equity. Further, the charter's principles align well with eco-social framework of health promotion that support planetary health research, action, and policy. The challenges in planetary health are shared, complex, and multiple, and we need strong principles to guide the diversity of action across our global contexts. We believe our suite of courses and the reflections offered here are translatable and useful across global contexts.

Table 24.1 discusses our reflection on the six triggering questions suggested by the editors.

Table 24.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion is a distinctive field of practice, set of principles, and, most importantly, praxis that informs and supports public health innovation, intervention, and action. This vision informed our decision to have our foundation course in HP required by all students seeking a Master of Public health degree. As such, health promotion has the potential to shape public health action through identifying human health concerns in the context of health of the planet, in order to define action that will affect systems change. One key example of this is how our foundation course in health promotion is situated in planetary health requiring students to be challenged by the complexity of health issues and to appreciate how human health is inextricably related to health of the planet

(continued)

Table 24.1 (continued)

Questions	Take-home messages
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	The University of Queensland is a large public university located in Southeast Australia. The School of Public Health (SPH) is located within a Faculty of Medicine. The SPH's mission is to "improve the health of populations in a changing and inequitable world". We have both domestic and international student cohorts and offer face-to-face and online engagement across all courses to accommodate students studying across distances. In addition, there are course offerings that offer a blended online student experience. Our MPH course is completed over 18 months and offers concentration in health promotion and disease prevention, global health, indigenous health, nutrition, and standard fields of study UQ has had in place a Reconciliation Action Plan (RAP) in 2019–2022 to address the ongoing history of colonisation of First Nations Peoples and to take meaningful action through "mutually beneficial partnerships and collaborations for shared learning, knowledge, language and culture"
Which theories and methodologies are used in the teaching-learning process?	We use a variety of theories to offer students choices in frameworks for action. In 7034, we use the Ottawa Charter to structure this course and apply the ecological model of public health (including eco-social and salutogenic approaches to health promotion) to the major assessment, the planetary health report. We introduce major theories of change in health, including the Health Belief Model, Stages of Change, Transtheoretical Model, Social Cognitive Theory and Theory of Reasoned Action/Planned Behavior, and Behavior Change Wheel in this foundation course, but these theories are directly applied in Health Promotion Planning (7035) and Evaluation (7036) courses
What kind of forms of assessment are applied, results achieved, and challenges faced?	We apply a variety of authentic assessment types in our health promotion suite of course. PUBH 7034: Reflective Blogs, Research Reports, Advocacy Letter. PUBH 7035: Measurement tutorial exercise (Pass/Fail), Health Needs Assessment Plan, Synthesis of Needs Assessment Findings, Action Plan Pitch Oral assessment task. PUBH 7036: Literature Review, Health Promotion Evaluation Plan, Implementation Pitch Oral Assessment Task. Students are challenged by the critical reflective assessments that ask them to reflect on their own standpoints in order to support safe practice in the field. We scaffold this learning activity through a focus on teaching the process of reflection both through theoretical framing (Bolam and Chamberlain) and also by modelling critical reflexivity in our teaching praxis both in and outside the classroom. The applied nature of our course challenges students to think creatively and concretely in terms of action, and while this is often difficult in the classroom environment, we meet this challenge by engaging stakeholders and HP researchers in delivery of course content

(continued)

Table 24.1 (continued)

Questions	Take-home messages
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	We have structured our programme to fulfil the Agency for Public Health Education Accreditation (APHEA), the International Union for Health Promotion Education (IUHPE) core competencies and professional standards for health promotion education, and the National Indigenous Public Health Curriculum Framework developed by the Public Health Indigenous Leadership in Education network. Our curriculum supports students in ethical, theory-informed practice in order to produce the next generation of change-making leaders. We engage the principles of health equity through crafting our teaching plans to foreground reflexive praxis and real-world engagement in advocacy, enabling and empowerment strategies, as well as mediation: the core skills of health promotion. This strong foundation guides our focus on community development, participatory methods of health promotion across the suite of courses to complement and inform more traditional methods of research and action
What could others learn with your experience? What is localized and what is "generalizable"?	Our experience in developing the health promotion suite of courses is shaped by our Australian context, both its history and the present moment. We serve a remarkably diverse cohort with student from around the globe, as well as diversity in our Australian cohort, including aboriginal and Torres Strait islander students. Unfortunately colonization is experienced in communities across the world, and so the learnings we share can inform other programmes as educators seek to decolonise their curriculum through critical reflexive pedagogy and weaving first peoples' knowledge into curricula to strengthen health promotion practice and support culturally safe classrooms. While the Ottawa charter is 35 years old, the principles are still applicable to the changing world. The concepts forwarded here align well with eco-social framework of health promotion that supports planetary health principles. The challenges in planetary health are shared, complex, and multiple, and we need strong principles to guide the diversity of action across our global contexts. We believe our curriculum offers such an example

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Chapter 25
Theoretical, Methodological, Mediatic, and Evaluative Challenges in the Teaching-Learning of Health Promotion: The Use of Virtual Platforms

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Introduction

This chapter presents the virtual teaching and learning process with an emphasis on health promotion (HP), in the sensu stricto postgraduate course in Collective Health, at the Pontifical Catholic University of Paraná (PUCPR) (Fig. 25.1).

Since its inception, we prioritize HP approaches according to World Health Organization (WHO) guidelines and the strategies of the Ottawa Charter and subsequent charters (Mittelmark, 2005; Porter, 2007; St Leger, 2007). We also address this field of knowledge as a result of our own doctoral works, which were completed in 1999, at University College London, whose publications serve as former references for the course (Moysés et al., 2003, 2006).

Early in the first decade of this century, we were already grounded on such principles and guidelines (Donchin, 2002), taking an instructional endeavor radically contextualized to our reality. The Ottawa Charter on Health Promotion defined HP as the process that allows people to increase control over their own lives and improve their health, in progressive actions that engender gains in empowerment, autonomy, and criticality. In the document, three main strategies for health promotion were presented: advocacy, training, and mediation. Still, great prominence was placed on policy implementation.

Successive HP global conferences, culminating in the last two conducted by the International Union for Health Promotion and Education (IUHPE) (Akerman et al., 2019; Massuda et al., 2019; Tu'itahi et al., 2019), endorse the centrality of HP in the struggles for the achievement of planetary health and sustainable development. We should defy the global inequalities and human footprints that harm our common home, under the Anthropocene (Moysés & Soares, 2019).

The main target of an educational proposal on HP should be the development of general and specific "competences" (Barry et al., 2012; Moreira & Machado, 2020), integrating with public health, recalling that HP is part of the so-called Essential Public Health Functions (Witt & de Almeida, 2003):

1. Monitoring, evaluation, and analysis of the population's health situation.
2. Surveillance, investigation, and control of risks and damages in public health.
3. *Health promotion* [emphasis added].
4. Citizen participation in health.

Fig. 25.1 Satellite image and aerial view of the PUCPR campus location

5. Policy development and institutional capacity for public health planning and management.
6. Strengthening of the institutional capacity for public health monitoring and assessment.
7. Evaluation and promotion of equitable population access to necessary health services.
8. Human development and public health training.
9. Ensuring and improving the quality of individual and collective health services.
10. Public health research.
11. Reducing the impact of health emergencies and disasters.

Competence is a polysemic concept; it can refer to many issues. Here, it refers to the combination of three domains: attitudes, knowledge, and skills (Fig. 25.2).

This happens through significant learning and authentic application, that is, competence put into action – "competence-in-situation" (Pinheiro et al., 2015; Scallon, 2015), or even the capacity to face complex demands in a particular context, a complex "know how" but also "make know," resulting from the integration, mobilization, and adaptation of capacities, knowledge, attitudes, motivations, values, emotions, and other sociocultural components, used in different ways, which are effective in real situations. It constitutes a complex and adaptive understanding, a knowledge applied, not in an uncritical and mechanical way but, reflexively, capable of adapting itself as meta-competence to a diversity of new contexts and situations. It also includes "knowing how to do," "knowing how to be," and "wanting to do," according to the desired purposes (Sacristán et al., 2011).

In summary, for operational purposes in our chapter, we understand the concept of competence as "the possibility of mobilizing an integrated set of resources, to solve a family of problems" (Scallon, 2015).

The chapter aims to share the description and exploration of theories, methods, and the use of technological means, in the educational process we nurture. The competencies in health promotion we seek to develop are based on high teaching-learning foundations, also indicating opportunities for research and work in the field that were opened for graduate students in Collective Health, at PUCPR.

Fig. 25.2 Competence for action, based on knowledge, skills, and attitudes/values. (Adapted from https://www.researchgate.net/figure/The-Future-of-Education-and-Skills-OECD-Education-2030-Framework-Knowledge-skills_fig7_326032010)

Context of the Experience

Structure, Objectives, Characteristics, and Profile of Participants of the Graduate Program at PUCPR

The PUCPR program has been utilized since 2005. It aims at the technical-scientific and social training of highly qualified masters and doctors for teaching, research, and management, prepared to meet the loco-regional and national demands of innovative strategies with an educational, social, and technological impact. This endeavoring purpose must be achieved with a critical and ethical core.

Its specific objectives are to empower the following:

1. Teachers, who are prepared to adopt instructional practices that encourage students to play a leading role in the development of professional, personal, and social skills.
2. Independent researchers, motivated to the nucleation and formation of research groups focused on qualified scientific production and with high socioeconomic impact, in line with technological and innovation trends.
3. Managers, capable of planning and executing public and private health promotion actions, connected to the economic, social, political, cultural, and environmental realities.

Graduates of the course have undergraduate degrees in nearly all health professions: Biological Sciences, Dentistry, Medicine, Nursing, Nutrition, Pharmacy, Physical Education, Physiotherapy, Psychology, and so on. To achieve the desired profile of the graduate, the curricular plan consists of three central axes of training, namely:

1. Didactic-pedagogical: promotes critical, reflective, and contemporary training related to teaching in higher education.
2. Scientific: promotes training in research methodology, scientific writing, and analysis of the literature for the development of critical thinking and scientific reasoning that culminates in original, ethical, and relevant research for society.
3. Social insertion: promotes teaching, research, and community outreach actions that involve the development of practices that contribute to the improvement of teaching (educational impact), public management (social impact), and health conditions (health impact). We put special focus on vulnerable populations.

In this context, the need to include HP in the curricular matrix has become mandatory, since the interdisciplinarity of its conception and applicability in interprofessional training were a common understanding of the program collegiate.

From Conception to Praxis: A 20-Year Trajectory

At PUCPR, HP has been discussed since 2000, coinciding with our return from the Ph.D. course in London, England. We introduced the theme as an interdisciplinary component in our undergraduate activities but especially in the sensu stricto graduate program.

In 2010, we published a paper that, among other aspects, summarized a decade of implementation of the initiative, with the timely assistance of a graduate student (de Mello et al., 2010). Now, our expectation is that the present chapter will allow us to advance in the account of two decades, including the citation of many works resulting from our supervision, be it academic research, co-production shared with health services, as well as leadership in national/international HP activities or events.

Both in 2010 and now, the perspective we maintain in relation to teaching-learning on HP is of a theoretical-practical-political arrangement (a praxis), which makes it possible to organize actions at the confluence of the academy, services, and the community. In addition to the obvious duty to offer interprofessional training for the thematic field, we urge policy makers and health stakeholders to implement the changes necessary to benefit groups who don't have basic rights in the society. We are attentive to the uncomfortable invisibility around issues of structural discrimination, such as sexism, homophobia, and institutional racism. The latter, in particular, unfortunately can thrive in university environments and affects black and indigenous people (Came & Tudor, 2020). One of our initial focuses was to conceive, implement, and disseminate the concept of health-promoting university (Fig. 25.3),

Fig. 25.3 Website of the healthy university, a project developed at PUCPR.

particularly in aspects such as intersectorality and healthy environments for all (de Mello et al., 2010).

In our context, such arrangements continue to move forward in both the education and health sectors in Brazil, throughout these first two decades of the third millennium. Our approach to public health services, in loco, as well as to political mobilization and social activism in favor of the National Health Promotion Policy was vigorous (Krempel et al., 2004; Moysés et al., 2004; Brasil. Ministério da Saúde, 2006, 2015;Rocha et al., 2014; de Sá et al., 2016; Moysés & Moysés, 2019).

We intend to explore the adoption of HP's broad benchmarks, as one of the significant aspects of change, in order to face certain disturbing characteristics of contemporary societies, such as economic austerity, ultra-liberalism, and individualism, which negatively affect professional and social relations, as well as outcomes on health/disease/care. It is necessary, then, to generate a heterogeneous universe of multi-competences, since the organization of modern health practice is necessarily interactive. It has professionals from various careers and levels of education-sharing spaces of initiative and co-responsibility, using their intellectual skills and views, with task coordination, communication, and information exchange.

Despite the fact that universities have, in general, a reputation for leading the frontiers of critical thinking and innovation, there are several cultural/institutional resistances in the academic milieu, in which professors operate inside disciplinary grids and micropowers encased in their respective chairs. When we problematize traditional training, there is a relative consensus among critics of the education of health professionals, regarding the fact that the biomedical, behaviorist, and procedural-centered model is hegemonic (Fry, 2019).

With its emphasis on clinical and laboratory-based experimental knowledge, the separation between individual and collective, private and public, biological and social, and curative-rehabilitation and promotional-preventive is reinforced. The instructional model that becomes dominant is organized in a compartmentalized way in curricular grids, fragmenting individuals into small parts. Thus, teaching is technical and concerned with the complexity of procedures, favoring intensive high-tech aggregation and, often, lacking an evaluation of effectiveness.

It is necessary to reach a consensus to make more porous the self-guard layer of teachers and their jurisdiction on disciplines, allowing the interpenetration of other fields and sources of knowledge. By betting that it is possible to innovate in interdisciplinary teaching and learning, we weave strategic spaces for HP to establish itself, advocating for its potential contribution to the health of specific population groups, with a consequent impact on the general population.

Health promotion, whether in the confined academic world, or in accessible services on or off campus, implies giving the population the necessary conditions to improve and exercise control over their health, raising voice for peace, education, housing, food, income, healthy ecosystems, social justice, and equity.

The following principles are what we look after (Moysés & Moysés, 2019):

1. Health must be an integral part of actions aimed at development.

2. Health can be improved by modifying the physical, social, cultural, scientific, and economic environment.
3. Conditions in social settings such as homes, schools, universities, communities, workplaces, and cities have a profound influence on people's health situation.
4. Intersectoral actions aimed at health are necessary at the "glo-cal" level.

Assuming the need for change, unavoidably linked to people's potential for life and health, we refer to the social production of health (and disease) and, consequently, to the HP field. We agreed that the world was different when the Ottawa Charter for Health Promotion was launched, over 30 years ago (Labonte, 2016). The acceleration of the ecological, economic, political, and social inequalities reflected in health, in a more complex and multi-polar world, presents dramatically new challenges for those who are committed to the original vision of the charter. Many of the objectives and goals of the Sustainable Development Goals (SDGs) provide signs of how far we are from what we need to achieve.

And yet, caution must be taken as to the implicit, naive assumption that the same economic system and its neoliberal governance rules, which created or accelerated our current era of ruthless inequalities and unprecedented environmental danger to planetary health, can, somehow, be harnessed to architect their own reverse (Moysés & Soares, 2019). These concerns have been discussed in the IUHPE Conference and in the thematic supplement of Health Promotion International issued in New Zealand, in 2019 (Fig. 25.4).

It could not be otherwise; at the base of our instructional actions, there is an expanded concept of health (Akerman et al., 2019; de Silva et al., 2020; Moysés et al., 2003, 2006). It evokes the need to create public policies to promote health, the imperative of social participation in the construction of the health system and policy, recognizing the impossibility of the health sector to respond alone to the changing determinants and guarantee healthy options for the population. HP evolves from thinking and acting in conjunction with other health-promoting social policies and technologies.

Therefore, it is essential that people and organizations assume their role in creating opportunities, choices, and healthy environments, through political commitment to sustainable development and the reduction of social and health inequalities.

All contemporary roles, demanded from universities, allow them to influence the health and quality of life of their members and the external community, contributing to knowledge and strengthening citizenship. Health-promoting universities – as well as health-promoting schools, in general – fit in the commitment to society, in its broad spectrum. In short, universities have the potential to contribute to health in three distinct areas:

1. Creating healthy work/learning environments for students, teachers, managers, employees, and users of their services.
2. Expanding the importance of health, health promotion, and public health in teaching and research.
3. Developing alliances with civil society and partnerships for health promotion and community action.

Fig. 25.4 Launch of the HPI thematic supplement in New Zealand, 2019

Succeeding Conjunctures of Social Policies and Health Services: A View to HP in the Last 20 Years

What needs to be known and taught to students, about policies and services?

In a review of the first decade of 2000, authors have discussed the institutionalization of HP practices in state bodies (Buss & de Carvalho, 2009). The authors warned that, at the time, more solid and national initiatives had been created to expand the institutional capacity to work with the different dimensions of HP. The 2006 Seminar on the National Health Promotion Policy, in Rio de Janeiro, was cited as a significant example, which brought together roughly 400 managers from the three governmental spheres, proposing to launch a national project for the large-scale training of professionals in HP, including using distance education methodologies.

A new account, for the second decade of the 2000s (Malta et al., 2014), pointed out that there have been advances in public management, such as the creation of a specific budget line, the inclusion of HP in the Plurennial Plan, monitoring of indicators in federative pacts, and the financing of HP projects in municipalities. Intersectoral actions implemented were relevant, especially the articulation with the sectors of education, justice, cities, human rights, social development, sports, and leisure, among others.

In the overtaking represented by this period, advances were observed in the health sector agenda in Curitiba, with our academic contribution. We deepened our partnerships and intersectoral actions, giving visibility to inequalities in the operational territories of primary health-care teams, as well as the concern with the sustainability of other sectors' actions (health in all policies). As shown in Fig. 25.5, we published our records on collaborative, integrated horizontal network, organized by our graduate group (Moysés et al., 2009).

With respect to the "settings" approach – an approach that we are very interested in on the course – a study evaluated the HP strategies used in Brazilian capitals (Silveira Filho et al., 2016, 2017). Mixed practices were identified at the level of primary health care, with better results favoring the richest of the South and Southeast regions and disadvantages for people living in the capitals of Mid-, North, and Northeast Brazil. Efforts are needed for teams to be qualified, especially for disadvantaged regions. For this, it is essential to align such interventions with the principles and values of health promotion, oriented to the social determinants of health (SDH) and to fight inequalities. Hence, an intersectoral activism is not yet based on praxis that has enough power to influence new governance architectures of public policies (Bueno, Moysés, et al., 2013).

Fig. 25.5 Publication on healthy environments/healthy settings in Curitiba, a work coordinated by PUCPR professors and graduate students

A specific type of intervention that calls our attention, both because it is our subject of research and also as it works with the educational context, is "health-promoting schools" (Gugglberger, 2021). Our research findings revealed that the respondents demonstrate necessary knowledge for intersectoral work, even though they need conceptual adjustments (de Ferreira et al., 2014). There was no participation of students in the definition of priorities, planning, and programming of actions. From another perspective, teachers' practices in relation to health promotion seemed to be focused on their students and their daily habits and practices. Teachers described the approach to health promotion through the content of the classes and suggested that the school seek help from other institutions in their activities.

Challenges for the Valuing of HP as a Curricular Thematic Field

Global health faces a wide spectrum of old and new challenges (Massuda et al., 2019). In addition to epidemiological problems, we have political conflicts, economic crises, and austerity policies that hamper progress toward HP, troubling the most vulnerable populations. Bearing in mind that HP is umbilically linked to knowledge and practices put at the service especially of disadvantaged social groups, as well as public health services (e.g., evidence production, institutional advice, policy formulation), difficulties arise for its embodiment in the university corpus, strongly oriented to the market.

During the IUHPE 22nd World Conference on Health Promotion, held in Curitiba, Brazil, in 2016, the challenges and threats to global health, in addition to a wide range of innovative experiences in health promotion, were discussed with participants from 65 countries. The symbolic-conceptual starting point of this conference was the recognition that "health is more than you imagine" (Fig. 25.6).

Fig. 25.6 Logo of the 22nd IUHPE World Conference on Health Promotion, Curitiba, 2016

At the end of the conference, a public declaration was approved demanding amplification of democracy and human rights in all countries as essential conditions for the promotion of health and equity (Akerman et al., 2019). At this conference, also led by the professors who authored this chapter, we sought to denounce the main threats to our democracy, contribute to debates and search for directions, as well as present our research productions. We found that the conference and its publicized products were a rich source for our students' research and learning.

Particularly in the offer and regular operation of our postgraduate program, it has always been in person, in the classroom on the PUCPR campus, in practice scenarios in the Municipal Health Network of Curitiba, or at events as mentioned in the IUHPE 2016 Conference. In its current configuration, its offer has been virtual (emergency remote education). In 2020, the year when the COVID-19 pandemic broke out, the teaching-learning challenging experience is worthy of being focused on in this chapter.

Another issue that proved to be challenging, in the context of the pandemic and the virtuality of classes and research activities, was the teaching-service-community relationship – deeply influenced in 2020. It turns out that the world of education may be more or less permeable to the world of health services, and vice versa, according to the historical strength of the exchanges existing in reality. In addition, health and education policies, in order to favor the training of professionals with an adequate profile for quality health care, cannot be restricted to undergraduation either. They also need to achieve specialization, residency, and postgraduate sensu stricto policies. It is not too much to remember the power, impact, and influence that graduate professors have on undergraduate school, with their status as knowledge producers.

Under the pandemic, we still advocate that the universities involved in HP programs can obtain many benefits, from enhancing their public image to their importance for local, regional, and national health services, enlightening institutional and pedagogical projects, including improving the quality of life of those involved. In academic terms, a common curriculum matrix that emphasizes HP has the potential to reinforce discussions on health in various training areas. It can increase the credibility of innovative research in the area, in addition to supporting a change in the focus of research, directing it more toward interdisciplinary themes.

Theories and Methods Used in Offering the HP Course (Last Edition of 2020)

The Search for a Coherent and Consistent Framework

In view of the general context, scenarios, conjunctures, and challenges presented, we are convinced that only robust theories and methods can underpin HP. They must be tested in the "noise" of the streets and forged in the heat of the struggles favoring

dispossessed communities, who are being resilient to the skepticism of the hegemonic education.

We assumed that, after the paradigmatic health revolution produced by infectious (or transmissible) diseases and then by the second revolution caused by chronic diseases, a third revolution was initiated, called the "new public health," in which the field of HP was putting itself, both in speech and in practice, as avant-garde (McQueen et al., 2007). However, in this third revolution – or fourth revolution, or health 4.0 (Moysés & Soares, 2019) – health promotion practices go beyond the field of public health: first, because it is not evidently set up as an academic scientific "discipline" or a typical professional "specialty" and, second, because many sectors, in addition to health, can engage in HP actions even with people without academic training.

However, the theoretical conciliation effort remains extremely complicated, in view of the epistemological framework of health promotion practices. Three major challenges are cited and are self-explanatory: complexity (von Heimburg & Cluley, 2020); contextualization (Moreira & Machado, 2020); and reflexivity (Alexander et al., 2020).

Principles, Pillars, Competences, and Approaches

This section aims to systematize the potential of HP in instructional activities, defining a theoretical model based on a matrix of key concepts. We explore the foundations of teaching-learning we adopt, leading to research practices and social protagonism that galvanize energies capable of facing and reducing situations of fragility of population groups, facing inequalities, and incorporating participation in society (Kusma et al., 2012).

An expressive part of the practices announced as "health promotion," mainly in undergraduate courses or at the level of primary care in health services, is still of narrow perspective. It focuses on lessons/practices limited to strategies based on old-style, "transmission" models, behavioral mindsets centered on "social hygiene," and talks aimed at lifestyle changes, among others (Silveira Filho et al., 2017).

It is known that some of these interventions have problems of operationalization and strength of scientific evidence, portraying inappropriate advices and social interventions. The serious limitations are because they do not produce sustainable improvements in the medium and long term in the health of the populations, being of a palliative nature, largely ignoring the structural factors that determine poor health, and, with an exasperating frequency, carrying the rhetoric of "blaming the victims." Paradoxically, one of the possible results of these actions is that inequalities, instead of being reduced, can be aggravated. Those who have more resources (material, cognitive, contextual) are more apt to benefit from the interventions carried out – the well-known phenomenon of the "reverse care law" (Hart, 1971).

On the other hand, it is essential to develop instructional actions based on multidimensional and intercomplementary concepts, working with evidence that

potentiate (positive) health protection factors. Consequently, they would rather address real problems in the community context, maintaining a fine tune with the defense of structural changes (Gelius & Rutten, 2018), to meet the health needs and demands in specific territories and population groups. The intents go beyond mere rhetoric, passing through decent work and income, sufficient and healthy housing and food, adequate sanitation, leisure, and a culture of peace and non-violence, among others. Cities, workplaces, schools, and areas where primary care teams work are examples of environments where such actions have been implemented, aiming to strengthen the role of the local level, encouraging equity, intersectoral collaboration, and community participation.

To develop such competencies in the HP training process is to reiterate the centrality of principles such as empowerment, emancipation, autonomy, and greater control over one's own life and health, in social and educational environments governed by respect for human dignity, in all its diversity, in other words, the synthesis view disseminated through the Ottawa Charter: a process of empowering people to increase control over and improve their health. Based on these principles, we establish pillars and instill values to gear up a health-promoting andragogy, triggered by a main device that is to challenge students and then mediate their search for inspiring and creative solutions (Lam, 2016).

The pillars, in this case, are understood as the theoretical bases for the generation of consensual canons in the thematic field, embracing here the search for equity, horizontal participation, and sustainability. Such pillars would be the mainstay for values, defined as the moral anchor for health promotion strategies, which include autonomy, empowerment, integrality, intersectorality, and accountability.

Our competency-building model for addressing challenges is shared with the Canadian "Circle of Health" model (Fig. 25.7), which provides the framework for theory and practice (https://www.innovationnewsnetwork.com/the-circle-of-health-exploring-health-promotion-frameworks/7257/).

The Circle is a tool that uses a holistic and progressive approach to public health, integrating health promotion principles, pillars, and strategies (Ottawa Charter), with a view to approaches on health determinants and key values. A simple learning guide supports it. Though it was developed and validated to meet local needs, this structure has been adopted nationally and internationally and is available in six languages – English, French, Spanish, Portuguese, Serbian, and German.

Each mobile circle, placed in layers, represents a body of knowledge. The orange circle represents holistic health, including physical, mental, emotional, and spiritual health. Yellow recalls the principles of the Ottawa Charter. Green aligns the various population groups with which one can work. Blue shows the health-disease-care determinants of the population. Reddish-purple represents the values and ethics we uphold at HP.

Fig. 25.7 The "Circle of Health" model. (Adapted from (https://www.innovationnewsnetwork.com/the-circle-of-health-exploring-health-promotion-frameworks/7257/)

Active/Interactive Methods We Use

Markedly, we seek most of the time to bring sustainable progresses in the training profile of interprofessional groups and, through their professional training, continuous improvements in the health outcomes of the populations served. These approaches include teaching activities such as situational diagnosis, discussion groups, flipped classroom, scenario solving, working groups for learning and problem-solving, project-based learning, and role-playing games. These approaches will be detailed below.

It is appropriate to present the constructive alignment of the course, that is, the circumstances to promote learning and "knowing how to be." Teachers, as the mediators, must be able to rethink their way of relating to students in promoting

meaningful learning. The taxonomy of meaningful learning helps to synthesize the purpose (Fink, 2013):

1. Fundamental knowledge, with a greater cognitive load, allows understanding and retention of information and ideas. It is the dimension of "learning to know," with critical autonomy and self-regulation. Students will recognize and understand terminology usual in the HP field. Therefore, this implies less in memorizing and more in acquiring in-depth knowledge of the key concepts used. For this, we use the inverted classroom, which instigates the student to seek and demonstrate knowledge, removing from the teacher his role as the exclusive holder of knowledge, as it leads him to a more complex condition of mediator in classroom. The idea is for the student to study previously selected material, using asynchronous virtual media, and make prior criticism so that he/she is already aware of the subject to be developed upon arrival in the synchronous room. In this way, the room becomes the place for teacher-student interaction, for example, to answer questions and build group activities.
2. The application involves introjection of skills, with critical, creative, and practical thinking, for example, the ability to manage projects in a network, with several partners from different backgrounds and with different knowledge. It is "learning to do." Students will be able to compare and contrast HP principles that, on purpose, can be presented in ambiguous or even opposite constructions, requiring an interpretation and plausible and convincing point of view. Another form of application is to use, in a broader horizon, the didactic workshop that teaches students the concept of teamwork in the elaboration of a (pre)project (project-based learning, PjBL). Many of these class (pre)projects have evolved into qualified and published dissertation and thesis projects themselves.
3. Integration is the time to connect ideas, people, and knowledge domains. Students will be able to apply the principles, the pillars, and the strategies, with certified competence, in order to approach and solve origins of problem situations, through extrapolation of contexts and metacognition. It is "learning to be."
4. The human dimension is an omnibus concept, as it brings personal ethical dimensions and subjective interpersonal relationships, opening space for group sociability. It nurtures reciprocal learning, that is, "learn to live together." Students use teacher and team reflection and feedback to identify areas where they have strengths and areas that need improvement. The environment, at the same time playful and professional, is valued for the multichannel learning that the group and, eventually, the involved communities provide.
5. Caring is an empathic disposition that is always desirable. "Take care of yourself, take care of others." Again, the call is to develop new feelings, interests, and values, motivated by the themes and problems that are in HP's repertoire. It is the dimension of "wanting to do" to materialize the common good. Students should want to apply the knowledge they have learned to the opportunities that appear in academic, professional, social, and personal life.
6. Finally, the certification of authentic competence occurs with "learning to learn," which is a lifelong process. This makes the student and the human being better,

with genuine interests that lead to inquire about new correlated issues, making self-oriented learning.

An instructional sequence will be presented as an example, from the "Instructional Plan" we used in 2020. Learning results were oriented by competences:

1. Knowing the theoretical milestones of HP, its foundations, concepts, and new convergent labels (global, planetary, unique health, and/or health in all policies) and differences between disease prevention and health promotion.
2. Discussing the National Health Promotion Policy (PNPS) and its application in health-care networks (RAS), with an emphasis on primary health care (APS) in Brazil.
3. Scrutinizing the current scientific production (state of the art) in the field of HP, including the formulation of intersectoral agendas for health-disease-care.
4. Identifying HP strategies and research (evaluation) methods and their strengths and weaknesses.
5. Reporting of successful experiences in HP (comprehensive concept) in national and international scenarios, considering their possibilities of application in different contexts.

As already mentioned, the virtual environment was used in the course, with synchronous and asynchronous activities. In short, monthly online meetings during the semester were held to discuss assignments to be carried out in asynchronous mode, allowing for a deepening and mediation of the knowledge process. The platform used was the one institutionally made available by PUCPR, Blackboard (Fig. 25.8) – in particular, Blackboard Collaborate™ (https://www.blackboard.com/teaching--learning/collaboration-web-conferencing/blackboard-collaborate).

In the succeeding monthly activities, the wanted learning results were broken down into seven class themes (each one with synchronous 4-hour workload per class and asynchronous with a 4-hour workload per class), totaling 56 h/class in the semester, as follows:

1. Mental map and benchmarks of health promotion (synchronous):
   (a) Mental map using GoConqr (https://www.goconqr.com/pt-BR): a diagram showing the organization of the content to facilitate associations among all the information highlighted in the teaching plan.
   (b) Situational diagnosis using Mentimeter (https://www.mentimeter.com/), for building a "word cloud" about the first idea that occurs when one thinks about HP.
   (c) Construction of a timeline, with the events/famous persons that the class had previously known in the field of HP, using Google Sheets Timeline (https://www.officetimeline.com/make-timeline/google-docs).
   (d) Dialogue presentation and debriefing of the timeline task, with complementation of information and deepening of the benchmarks (screen sharing, with microvideos and slides).
   (e) Formation of subgroups for the assignment of asynchronous tasks.

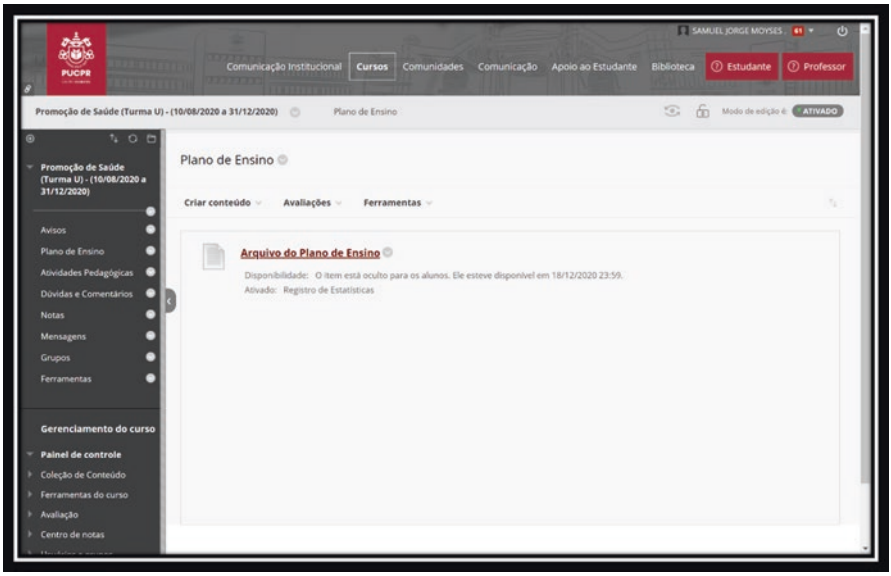

Fig. 25.8 Screenshot of the Blackboard platform made available for virtual classes at PUCPR

2. National Health Promotion Policy in Brazil: convergent agendas (asynchronous > synchronous):
   (a) Flipped classroom, with references and electronic sites available for individual offline readings and work in subgroups, with a script of questions that generate doubts, ambiguities, and decision-making conflicts.
   (b) Online activity, with random dedicated subgroups, on the Blackboard platform, so that each subgroup presents its responses to peers and makes the discussion.
   (c) Return to the main virtual room, online, for mediation by teachers and collective feedback.
   (d) Use of apps like Kahoot! (https://kahoot.com/), Socrative (https://www.socrative.com/), or Mentimeter (https://www.mentimeter.com/), to gamify activities, respond to problem situations, and resolve conflicts in simulated scenarios.
3. Retrieval of scientific production and technical innovations in the field of HP (asynchronous > synchronous):
   (a) Flipped classroom, with available references selected by the teachers, for individual readings offline and work in subgroups.
   (b) Request to complement references, with autonomous search, meeting criteria of relevance, consistency, and timeliness.

(c) Online activity, with random dedicated subgroups, on the Blackboard platform, so that each subgroup presents its considerations about the state of the art and proceeds to the discussion.
(d) Return to the main virtual room, online, for mediation by the teacher and collective feedback.
(e) Use of apps like Kahoot! (https://kahoot.com/), Socrative (https://www.socrative.com/), or Mentimeter (https://www.mentimeter.com/), to gamify activities, respond to problem situations, and resolve conflicts in simulated scenarios.

4. HP (evaluative) research methods (asynchronous > synchronous):

(a) Flipped classroom, with available references selected by the teachers, for individual readings offline and work in subgroups.
(b) Online activity, with random dedicated subgroups, on the Blackboard platform, so that each subgroup presents the main methods studied, evaluates strengths and weaknesses, controls bias, and proceeds to the discussion.
(c) Return to the main virtual room, online, for mediation by the teacher and collective feedback.
(d) Use of apps like Kahoot! (https://kahoot.com/), Socrative (https://www.socrative.com/), or Mentimeter (https://www.mentimeter.com/), to gamify activities, respond to problem situations, and resolve conflicts in simulated scenarios.

5. Health promotion practices: reports on published HP actions, involving settings, service networks, social equipment, cities and municipalities, as well as public, philanthropic, or private sector institutions (asynchronous > synchronous):

(a) Flipped classroom, with autonomous search for references, for individual offline readings and work in subgroups.
(b) Online activity, with random dedicated subgroups, on the Blackboard platform, so that each subgroup critically presents the selected and prioritized experiences, with their successes and failures: basic theory, principles/pillars/strategies/values/approaches identified in the reported experiences, proceeding to the discussion.
(c) Return to the main virtual room, online, for mediation by the teacher and collective feedback.
(d) Use of apps like Kahoot! (https://kahoot.com/), Socrative (https://www.socrative.com/), or Mentimeter (https://www.mentimeter.com/), to gamify activities, respond to problem situations, and resolve conflicts in simulated scenarios.

6. Production of evidence in health promotion: proposal of (pre)projects to demonstrate authentic competences, certifying achieved abilities. In other words, "to mobilize an integrated set of resources in an internalized way in order to solve a family of problem situations," answering challenging questions identified in previous activities (asynchronous > synchronous):

(a) Project-based learning (PjBL), offline, with the design of intervention projects in problematized and contextualized realities.
(b) Online discussion, with mediation by teachers, on the direction of the proposed (pre)projects, their possible use for main or complementary projects of dissertations and theses, or for use in services, or communities.

7. Self-assessment (synchronous):

(a) Application of a (self-)assessment instrument, which includes a Likert scale with options that score from 1 to 5. Learning units, teachers, and students are evaluated. There is an open space in the instrument for the expression of comments, doubts, criticisms, and praises, among other wishes for feedback given by students.
(b) Closing celebration with exchanges of virtual affability.

Broad Conceptualization of the Evaluation Process

Evaluation in health promotion is a methodological and strategic challenge in any field of action, whether in the instructional space, in policies or services, or even in community intercessions. Our assessment process goes beyond the obvious and necessary formative/summative requirements of the classroom, including grades and attendance, to reach spaces outside the academy.

We have adopted the evaluation model (Fig. 25.9), which allows the formation of competencies for decision-making based on "evidence" in collective health and HP (https://www.nccmt.ca/about/eiph). We agree that evidence assessment is the process of distilling and disseminating the best knowledge available.

We look for evidence that does not produce an epistemocentric reduction of thought, that is, that respects a diversity of sources – this means epistemic plurality and consideration for local knowledge. That includes health issues and their apprehension in the community, existing data in public health services, ethnographic and qualitative reports from identitarian groups – in their political climate – as well as the best results of academic research available.

Therefore, the first step in the evidence-based process is to clearly define – and preferably in interdisciplinary work or, where possible, participatory network – the question or problem in a searchable and answerable format. This step in the process helps to answer the following questions: Who is my target group? What is the issue we are dealing with? What specifically are we trying to change?

A clearly defined issue or problem is the starting point for an effective search for evidence sources. This stage of the process helps to answer the question: "Where should I look to find the best available research evidence to address the issue?"

Critical evaluation is the process of evaluating the quality of the study methods to determine whether the findings are reliable, meaningful, and relevant to the situation. It helps answer the question: "Were the methods used in this study good enough that I can be confident in the findings?"

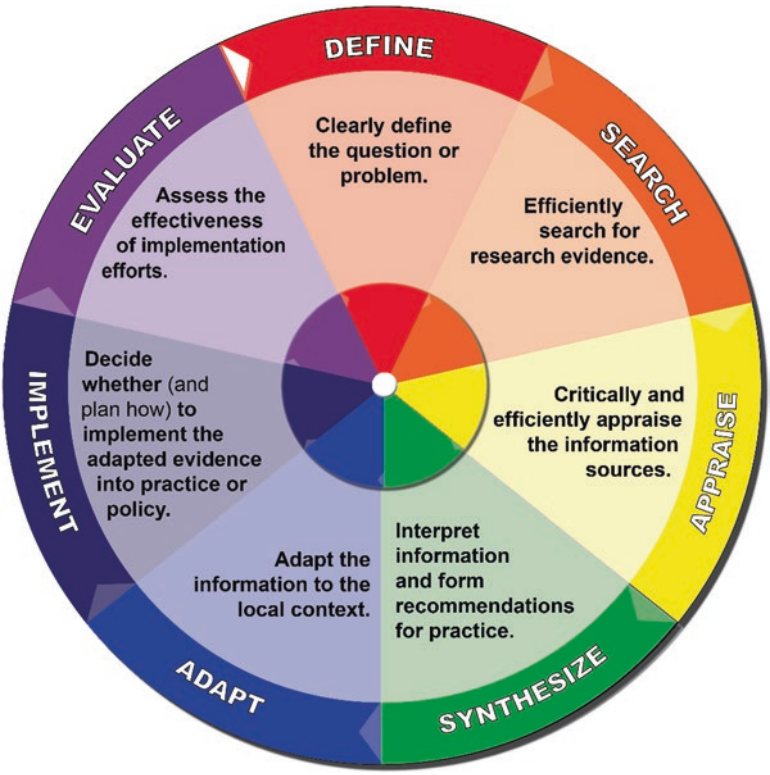

Fig. 25.9 Evaluation model based on the evidence-informed public health tool. (From: https://www.nccmt.ca/tools/eiph)

The fourth stage of the process focuses on decoding the "actionable messages," based on the revised evidence. Recommendations should be compiled from evidence of the most synthesized and highest integrity available. This step helps to answer the question: "What does the research evidence tell me about the issue?"

The fifth step is to adapt the evidence to the local context. This step helps to answer the question: "Can I use this research with my user, community, or population group?"

Implementation involves acting on the evidence to bring about a change in practice, for example, in our case, the production of a (pre)project of intervention on HP that allows the certification of authentic competence. This step in the process helps answer the question: "How will I use the research evidence in my practice?"

The final step involves evaluating the effectiveness of the implementation efforts and the sequence of the evaluative circuit in continuous looping. This step helps to answer these two questions: "Did we do what we planned to do?" "Did we achieve what we expected?"

Learning Outcomes, Knowledge Gains, and Activation of Changes

Our commitments are organized in a fourfold approach: teaching, research, providing services to society, and militancy in health promotion. Along with academic teaching and research work, we have consistently participated on the following:

1. The production/publication of research with our students and academy and life companions (Moysés et al., 2003; Krempel et al., 2004; Moysés et al., 2004, 2006, 2009; Bueno et al., 2010; Gaio et al., 2010; de Mello et al., 2010; Kusma et al., 2012; Bueno, Moysés, et al., 2013; Bueno, Tetu Moysés, et al., 2013; de Ferreira et al., 2014; Schwab et al., 2015;Silveira Filho et al., 2016, 2017;Moysés & Soares, 2019; Moysés & Moysés, 2019; de Baltazar et al., 2019).
2. The participation in the formulation, implementation, and review of the National Health Promotion Policy in Brazil (Brasil. Ministério da Saúde, 2006, 2015).
3. Co-creation of policies, plans, actions, and services in municipalities and training teams (including graduate students) or supporting decision-making by managers. There are two examples: (a) anchor project healthy living, for health in all policies, which is an example of how public policies, of a populous capital in the Global South, can be influenced around a common axis, negotiated with teachers/researchers working at the front of the academy (Krempel et al., 2004; Moysés & Franco de Sá, 2014; Moysés & Moysés, 2019) and (b) policy design in municipalities in the metropolitan region of Curitiba (Bueno, Moysés, et al., 2013; Bueno, Tetu Moysés, et al., 2013).

Future Challenges to Always Be Considered

There are still restrictive forces identified in the implementation of HP programs and projects, whether in the academy, services, or other social settings. We know that many traditional experiences, called by their authors as “health promoters,” are still carried out in an isolated, microdisciplinary way, with low institutional sustainability. They depend on the voluntarism of a few teachers, students, frontline workers in social policies, or community leaders with almost no power within the policy of the institutions but with some authority of vocalization.

We commonly face cultural resistance within institutions, rooted for many decades in the Cartesian and positivist model that induces fragmentation, mechanization, and disciplinarization. As such, we see a high ideological commitment to high-tech care components and a low status quo credited to health promotion practices.

It is a common institutional ethos dominated by the culture of “corporations,” with a focus on the market and private practice, that makes integration with the public sphere difficult. Therefore, a relative ambiguity and conceptual confusion

flourished, in which many agree (in theory) with the proposals of the HP, often considering them "noble" or "beneficent" but revealing great unfamiliarity (or lack of interest) in its operationalization.

Potential for Application in Other Contexts: The Local and the Global (glo-cal): Comparable International Experiences?

A "Matrix of Essential Competencies in Health Promotion (CompEPS)" has been discussed both nationally and internationally (Moreira & Machado, 2020; Pinheiro et al., 2015). The initial material that triggered the preparation of the matrix was the European document from the project Development of Skills and Professional Standards for Training in Health Promotion in Europe – the CompHP. CompHP was developed in Europe in 2012, with the aim to establish competencies and a certification system for health promotion (Barry et al., 2012; Speller et al., 2012).

Despite the fact that the CompHP guidelines have been coined to think about training and practice in health promotion in the European context, its characteristics as a model of professional training can benefit a lot of countries like Brazil and vice versa.

Therefore, there is a common basis for the instruction and qualification of competences for actions that effectively promote health, whether in Curitiba or in any other context. For that, it is enough to have (com)passion for people, interest in the potential of HP, and the will to change the inequalities that destroy people, families, and societies.

Table 25.1 discusses our reflection on the six triggering questions suggested by the editors.

Table 25.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	*Our vision is in line with the WHO and the Ottawa Charter, as well as subsequent Charters and declarations, on HP. It is defined as the process that allows people to increase control over their own lives and improve their health, with gains in empowerment, autonomy, and criticality. We endorse HP's centrality in the struggles for planetary health and sustainable development. We must challenge the global inequalities and human footprints that undermine our common home, under the Anthropocene*
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	*The PUCPR course takes place since 2005 annually, counting about 60 hours. It aims at the technical-scientific and social training of highly qualified masters and doctors for teaching, research, and management. They are prepared to meet the loco-regional and national demands for innovative strategies with educational, social, and technological impact. Graduates have degrees in almost all health professions: Biological Sciences, Dentistry, Medicine, Nursing, Nutrition, Pharmacy, Physical Education, Physiotherapy, Psychology, and so on*

(continued)

Table 25.1 (continued)

Questions	Take-home messages
Which theories and methodologies are used in the teaching-learning process?	*We intend to explore the adoption of HP's broad benchmarks, as one of the significant aspects of change, in order to face certain disturbing characteristics of contemporary societies, for example, economic austerity, ultra-liberalism, and individualism, which negatively influence professional and social relations, as well as outcomes on health-disease-care. Health promotion, whether in the confined academic world or in accessible services on or off campus, implies giving the population the necessary conditions to improve and exercise control over their health, raising voice for peace, education, housing, food, income, healthy ecosystems, social justice, and equity. Assuming the need for change, unavoidably linked to people's potential for life and health, we refer to the social determinants of health (and disease). Approaches include teaching activities such as situational diagnosis, discussion groups, flipped classroom, scenario solving, working groups for learning and problem-solving, project-based learning, and role-playing games*
What kind of forms of assessment are applied, results achieved, and challenges faced?	*Our commitments are organized in a fourfold approach: teaching, research, providing services to society, and militancy in HP. we adopt an evaluation model, which allows the establishment of competencies for decision-making based on "evidence." We agree that evidence assessment is the process of distilling and disseminating the best knowledge available. We look for evidence that does not produce an epistemocentric narrowing, so, considering a diversity of sources, this means epistemic plurality. That includes health issues and their apprehension in the community, existing data in public health services, ethnographic reports, as well as the best results of academic research available. Despite the challenges faced, such as the culture of "corporations," with a focus on the market, private practice,* and *ideological commitment to high-tech care components, we have consistently participated on the production/publication of research with our students and academy and life companions and co-creation of policies, plans, actions, and services*
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	*To develop competencies in the training process is to reiterate the centrality of principles such as empowerment, emancipation, autonomy, and greater control over one's own life and health, in environments governed by respect for human dignity, in all its diversity, in other words, the synthesis view disseminated through the Ottawa charter: a process of empowering people to increase control over and improve their health. Based on these principles, we establish pillars and instill values to gear up a health-promoting andragogy, triggered by a main device that is to challenge students and then mediate their search for inspiring and creative solutions. Pillars are understood as the theoretical bases for the generation of consensual canons in the field, embracing here the search for equity, horizontal participation, and sustainability. Such pillars would be the mainstay for values, defined as the moral anchor for health promotion strategies, which include autonomy, empowerment, integrality, intersectorality, and accountability*

(continued)

Table 25.1 (continued)

Questions	Take-home messages
What could others learn with your experience? What is localized and what is "generalizable"?	*A "matrix of essential competencies in health promotion (CompEPS)" has been discussed nationally and internationally. There is a common basis for the training and qualification of skills for actions that effectively promote health, whether in Curitiba or in any other context. For that, it is enough to have (with) passion for people, interest in HP's potential, and willingness to change the inequalities that destroy people, families, and societies. As long as they are properly contextualized in specific contexts, all the experiences exposed in the chapter can be adjusted and applied elsewhere, in particular, classes in virtual format*

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Part IV
Special Topics for Health Promotion

Chapter 26
Introduction to Part IV: Special Topics for Health Promotion

Alfredo Pina and Sylvie Gendron

The coronavirus disease 2019 (COVID-19) pandemic accelerated many changes in virtual and face-to-face educational processes, enriched by digital information and communication technologies (ICT). In this context, teaching health promotion with a focus on meaningful, collaborative, and interprofessional learning represents a challenge for educators, academic managers, and other professionals involved in undergraduate, graduate, service education, and massive open online courses (MOOC).

The six chapters included in this section indicate diversified strategies to encourage an education committed to the subjects involved, constructing socially relevant knowledge and searching for a more equitable, sustainable, safe, and solidary society.

In Chap. 27, "Personalized and research-led teaching as building blocks to success during pandemic times in Austria's Higher Education sector," professors and researchers from the health department of the Burgenland University of Applied Sciences present good practices related to hybrid teaching and active methodologies in health promotion undergraduate and graduate courses. It is noteworthy that this Austrian experience highlights many opportunities to improve health promotion skills based on learners' needs for the effective use of available technological resources and continuous assessments to ensure good professional training quality.

Chap. 28, "Health Promotion and Integrative and Complementary Practices: transversality and competence development in an undergraduate experience,"

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presents innovative interprofessional education strategies to integrate undergraduate students, professors, service professionals in the territory, and representatives of the local community in a coastal city in Santos, SP, Brazil. The teaching of integrative and complementary practices exemplifies an excellent way to create bridges between technical and popular knowledge to transform health care and develop skills culturally sensitive to the population's needs.

The importance of the role of health-promoting universities in the care network for students is evident in Chap. 29, "Teaching suicide prevention: experiences from a social-ecological approach." The authors present experiences related to training in psychology and partnerships with schools in the local community to work on suicide prevention, without ignoring other dimensions of comprehensive human care and the expansion of skills to promote health in scenarios related to a renowned public university in the Brazilian capital.

Improving qualified and sensitive listening to the plurality of people's ways of living from the perspective of interprofessional education is thoroughly detailed in Chap. 30, "Encounters and narratives: the insertion of the socio-environmental health in the perspective of the health promotion." It is an experience full of dialogues between students and professors of undergraduate courses in health at the Baixada Santista campus of the Federal University of São Paulo (UNIFESP) and successive approaches to daily life, problems, and opportunities representatives of the local community.

Chap. 31, "Health education in times of pandemic: promoting health among indigenous populations in the Brazilian Amazon," describes and analyzes the creation of a MOOC focused on promoting indigenous mental health. The integration of methodologies and intercultural dialogues with community leaders stood out in translating relevant knowledge and practices for the collaborative construction of the aforementioned online course. Finally, the authors present potentials, points for improvement, and challenges to develop a virtual learning environment sensitive to health needs and specificities to reduce the vulnerabilities of indigenous peoples.

Chap. 32, "Health Promotion and Work in/with Groups: an experience of interprofessional training in UNIFESP - Baixada Santista (São Paulo/Brazil)," strives for interprofessional educational processes in undergraduate health that promote comprehensive care based on plural groups and collective spaces. This project aims to face inequities in health and empower all those involved: students, professors, community representatives, and other stakeholders.

All chapters evince the use of teaching strategies, digital technological resources, and evaluation processes to ensure excellent education quality in the current COVID-19 scenario.

Finally, the chapters in Part 4 present inspiring, creative, and relevant experiences to provide greater integration between higher education institutions, research institutions, and local services to meet the health needs of individuals, social groups, and communities. Therefore, developing skills to encompass the versatility and variety of health promotion topics becomes an ethical imperative and a fundamental strategy to face the complex situations of an increasingly interdependent and interconnected world searching for "One Health" for all.

Chapter 27
Personalized and Research-Led Teaching as Building Blocks to Success During Pandemic Times in Austria's Higher Education Sector

Erwin Gollner, Barbara Szabo, and Florian Schnabel

Contents

Introduction

Since the academic year 2002, it has been possible to complete a study programme with a focus on health promotion in combination with health management at the University of Applied Sciences Burgenland. Originally an eight-semester diploma programme, it has continuously developed with regard to both contents and didactics. Today, the Department of Health at the University of Applied Sciences

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Burgenland offers a variety of university degree programmes focusing on health promotion, which is unique in Austria. These programmes include:

- A six-semester bachelors' degree programme in Health Management and Health Promotion (full-time), completing with the degree of Bachelor of Arts in Business (BA), providing 48 study places per year (altogether 144),
- A consecutive masters' programme in Health Promotion and Human Resource Management (part-time), leading to the degree of Master of Science in Health Studies (MSc), offering 25 study places per year (altogether 50).
- A second consecutive masters' programme Health Management and Integrated Care (part-time), leading to the degree of Master of Arts in Business (MA), offering 25 study places per year (altogether 50).
- Two six-semester health profession study programmes Health Care and Nursing and Physiotherapy, completing with the degree of Bachelor of Science in Health Studies (BSc), providing 28 study places per year in each study programme (altogether 84 in each study programme).

In this paper the underlying framework and didactical principles of those study programmes focusing on health promotion, namely, Health Management and Health Promotion as well as Health Promotion and Human Resource Management, are presented. The implementation of the didactical principles and success factors and challenges concerning the COVID-19 pandemic are further contents of this paper.

To start with, the initial situation is described by giving an overview of education and training in the field of health promotion in Austria. In addition, current developments in a university setting and its demands on teaching are discussed.

Health-Promotion Education and Training in Austria

Thirty-five years after signing the Ottawa Charter, the field of health promotion is undergoing dynamic development. In addition to research and practice, this also applies to education and training in the field of health promotion in the tertiary education sector. In Austria, there is also an increasing interdisciplinarity in the field of health promotion: on the one hand, health professions such as qualified health and nursing staff, physiotherapists, occupational therapists, dieticians, nutritionists and sports scientists and also professions such as psychologists and sociologists are involved in health promotion, partly due to statutory provisions. In addition to integrating the topic of health promotion into basic training, these professional groups also get further and advanced training in health promotion.

On the other hand, in the past 35 years, due to the increasing importance of health promotion in society, its development and the associated increasing complexity, study programmes in the field of health promotion and public health have been established at university level. According to Blättner et al. (2015), this development should ensure that health promotion interventions are initiated according to strict methodological criteria and are evidence- and theory-based. This is also referred to

as the academization of health promotion. For a long time, the "School of Public Health," which was founded in 1986 in Innsbruck but no longer exists today, was the only study programme in Austria with public health content. In 2013, 3 postgraduate public health university programmes, 2 public health doctoral programmes and 34 study programmes that addressed specific aspects of public health already existed (Diem & Dorner, 2014). In recent years, these kinds of study programmes have continued to grow further.

While this seems to be a good development, the comparability of the quality of different study programmes presents a big challenge. In contrast to medical, therapeutic and nursing professions, there is no regulation concerning the occupation of health promotion. Thus, the title "health promoter" is not yet protected by professional laws. However, applying the principles of health promotion is a complex, professional service. Professional health promoters have to have a comprehensive bundle of competences to do so. In addition to basic knowledge and practical skills, scientific competences are very important for evidence-based and need-oriented implementation of health promotion.

Requirements: Flexibility and Transformation

In addition to the (different) competency demands, students within a specific cohort often have different interests, motives, goals and prior knowledge. This requires a high degree of flexibility and openness from teachers. Thus, in addition to the general content requirements for education in the field of health promotion, the different approaches and needs of the students have also been integrated into its teaching. Ideally, customized content and contemporary media offerings should be linked with the interests, competences and potentials of the learners.

The COVID-19 pandemic and the associated social distancing reinforced the need for digital, flexible and personalized teaching and learning opportunities at universities. Didactically, universities had to undergo a digital transformation. They were called upon to revise or further develop teaching concepts and increasingly rely on online-based or hybrid formats (Surov et al., 2021). Since Ottawa, the principle of health promotion has been followed, allowing setting development through sustainable structure building. In pandemic times, however, there are "prescribed frameworks" that are supposed to bring about a certain obligatory behavioural change. Analogously, social distancing has also been prescribed for universities to reduce the risk of infection. Distance learning concepts have been implemented.

How the Health Department at the University of Applied Sciences Burgenland responded to these ongoing developments in particular is being discussed in this paper.

Framework

In order to meet current challenges in the healthcare sector and to develop solutions from a health promotion perspective, it was necessary to define qualifications and competences that students in health promotion study programmes at the University of Applied Sciences Burgenland should have. Relevant concepts for the definition of qualification goals and competences to be acquired in the bachelors' degree programme Health Management and Health Promotion as well as in the consecutive masters' degree programme Health Promotion and Human Resource Management are:

- The CompHP Core Competencies Framework for Health Promotion at European level.
- The outlines of a new health education policy at the level of the *DACH region* (including Germany, Austria and Switzerland).

CompHP Core Competencies Framework for Health Promotion

In this chapter an overview of the CompHP Core Competencies Framework for Health Promotion is given. The framework is an internationally agreed recommendation paper for core competencies, guidelines and professional standards of health promotion. In this chapter the focus lies on the integration of the CompHP framework in the teaching concept of the health promotion study programmes at the University of Applied Sciences Burgenland.

The reason why the CompHP Framework was developed by the IUHPE between 2009 and 2013 was the shared opinion of health promotion experts from various countries that, due to the diversity of actors involved in health promotion, a specific core of knowledge, skills and expertise was needed. This should represent health promotion practice and contribute to effective, high-quality and ethically correct health promotion. The CompHP framework includes 11 competencies, which are a "minimum set" of health promotion competencies that provide a basis for programmes, projects and initiatives in health promotion (Barry et al., 2012):

- *Ethical values* underpinning the CompHP Core Competencies – Ethical health promotion is based on a belief in equity and social justice, respect for the autonomy and choice of both individuals and groups and collaborative and consultative ways of working.
- *Health promotion knowledge.*
- Standards as specific aspects of health promotion practice – *enable, mediate, advocate, leadership, communication, needs assessment, planning, implementation, evaluation and research.*

The 11 competencies were the basis for defining learning objectives, modules, courses and concrete contents of the study programmes. They are an integral component of all health promotion courses in each study programme.

As evidence-based health promotion is an important part of the CompHP framework, it reinforces the meaning of research-led teaching and learning in the Health Department at the University of Applied Sciences Burgenland. In addition, the specifically formulated competencies in the CompHP framework help to design the contents as well as the didactic design of courses in this field.

The CompHP framework also shows that health promotion experts need competences on different levels. In this context, the defined competences help to continuously develop the mode of courses (e.g., practical projects, management techniques).

In addition to requirements for health promoters, the CompHP framework also includes an implementation plan for the development of a European qualification and accreditation system. Furthermore, an IUHPE course accreditation for the masters' programme Health Promotion and Human Resource Management in 2021 is planned.

The rather general description of the 11 core competencies allows them to be used in different situations, different settings and different geographic regions as well as in a variety of application contexts. They offer universities in the field of health promotion the possibility to place themselves in practice, study and research on an international scale. In doing so, the path is cleared from the "disorganized professional jungle" toward a transparent, professional and high-quality health promotion practice.

Outlines of a New Health Education Policy in the DACH Region (Including Germany, Austria and Switzerland)

Also important for the definition of qualification goals within the health promotion study programmes in the Department of Health at the University of Applied Sciences Burgenland was the careum working paper 7 "Outlines of a new health education policy". The aim of this paper was to create a framework for the *DACH region* (region including Germany, Austria and Switzerland) to answer the following question: Which educational strategies and structures are needed to train the right professionals for the health systems of the twenty-first century? (Sottas et al., 2013). Due to the increasing role of health promotion within Austrian health policy, this question is also very important for the development of study programmes in the field of health promotion.

Sottas et al. (2013) emphasize in this working paper that for an effective health system with high health benefits, different professionals and occupational groups with different degrees of expertise should work together. The authors define four working areas:

- Functions at population level, especially health promotion, prevention and public health
- Functions at organizational level, especially strategy, control, management, financing, technology and logistics
- Functions at patient level, in particular patient treatment, diagnostics, therapies and rehabilitation
- Knowledge-enhancing functions, especially research, evaluation, health impact assessment and quality assurance

Within the bachelors' degree programme Health Management and Health Promotion at the University of Applied Sciences Burgenland, students already acquire functional competences within population-, organization- and knowledge enhancement-related fields. These are strengthened and expanded in the masters' degree programme Health Promotion and Human Resource Management.

Didactic Principles

Based on the developments and frameworks explained in the previous sections, the core objective of the health promotion study programmes in the Department of Health is to train qualified health promotion experts who can:

- Identify and analyse health challenges at a national and international level from a health promotion perspective.
- Plan and conduct studies according to ethical principles.
- Formulate concrete goals.
- Develop and evaluate innovative, evidence-based approaches to promote the health of the population, considering ethical principles and principles of health promotion.

In order to achieve these goals, it is necessary that students are enabled to make decisions regarding population health; to advise others by preparing appropriate information, to plan, implement and evaluate needs-based measures; to define and seek answers to health science questions; and to take responsibility for the national and international development of health promotion.

Keeping these objectives in mind, two closely related central didactic principles were pursued and implemented within the study programmes.

Personalized Teaching and Learning

About 5 years ago, a personalized teaching and learning strategy was established at the University of Applied Sciences Burgenland. This strategy is an essential basis for the didactic design of the bachelors' degree programme Health Management

and Health Promotion and the masters' degree programme Health Promotion and Human Resource Management. The aim of this strategy is to involve students appropriately in the teaching and learning processes. The interests and experiences of students should be integrated into the organization and design of courses by combining tailored content and contemporary media offerings with the interests, competences and potentials of the students.

In the following paragraphs, four essential aspects of personalized teaching are explained in more detail. It is shown how these are considered in the health promotion study programmes.

Interests, Motives and Goals

People who decide to study health promotion have specific, sometimes very different, interests, motivations and goals. This becomes particularly clear in the case of students who are already working and who are participating in the part-time masters' programme Health Promotion and Human Resource Management. Some students who are already working as health professionals want to deepen their knowledge in specific fields; others are seeking a new direction in their own professional career.

To meet these different needs and interests, the authors of this paper believe that it is necessary to identify them already during application phase. For this reason, people who want to study within the masters' programme Health Promotion and Human Resource Management have to develop a project concept and present it at the interview, which is an essential part of the application process. The project concept should represent an initial idea for the implementation of a real project in the field of health promotion. Applicants can link this project concept to their own professional experience, which enables a later deepening in this field of work. It is also possible to open up previously unknown fields independently of one's own current professional background, e.g. by contacting organizations in the health sector or representatives of local authorities.

Students who get the opportunity to secure a position within the masters' programme can continue to work on their project idea, whereby specific aspects will be explored in more detail. For this purpose, a specific module has been defined for each semester. In the first semester, for example, the module "Social Science and Epidemiological Methodological Competence" consists of the courses "Social Science and Epidemiological Methods of Health Sciences", "Biostatistics I & II" and "Health Data, Data Visualization and Reporting". The core task for the students in this semester is to define and apply adequate health science methods within their project concept. In the module "Design of Health Projects", which includes the courses "Risk and Crisis Management", "Project, Programme and Process Management" and "Evaluation and Monitoring of Health Projects", the focus is on the conceptual development of an evidence-based implementation process in a defined setting. In the module "Social and Leadership Competence", which consists of the courses "Culturally Sensitive Project Communication", "Change Management

in Health Projects", "Moderation Technique and Conversation" and "Corporate and Leadership Culture", the focus is on the topics of change and the use of resource-oriented project moderation to better reach the target group. In the module "Innovative Project" in the fourth semester, the course "Project Work III" is linked with the courses "Masters' Thesis Preparation Seminar" and "Forum for Innovations and Problem Solving". Here, the focus is on the scientific conception of the practical project in the form of the creation of a Masters' thesis, which centrally relates to this project. Figure 27.1 shows the process of conceptualizing the project.

To deepen the individual interests of the students, it is also possible to specialize in both the bachelors' and the masters' programme. In both programmes, students choose a specialization from the third semester onward, in which they can deepen their knowledge depending on their interests, motives and (career) goals. Students' individual interests are also considered when writing their bachelors' and masters' thesis.

Professional Background, Prior Knowledge, Skills, and Competences

Most students in the masters' programme Health Promotion and Human Resource Management and some students in the bachelors' programme Health Management and Health Promotion work alongside their studies. In addition, some already have several years of professional experience in various fields. Besides taking into account the professional background, the individual prior knowledge and the different competences of the students, it is a central goal of the study programmes to prepare the students for future professional practice and, in particular, to ensure the applicability of what they have learned in a professional context.

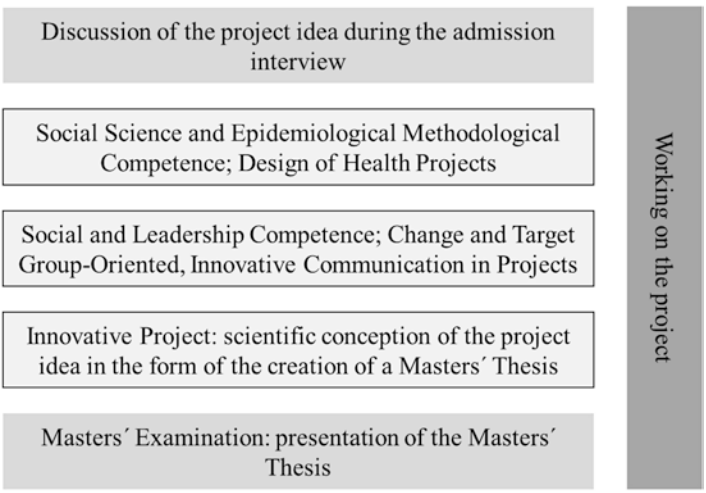

Fig. 27.1 The process of conceptualizing the project

To achieve this goal in the bachelors' programme "Health Promotion and Health Management", the curriculum includes the following:

- Working on case studies and practical examples in individual courses
- Participation in a real project in the field of health promotion in the fourth semester
- Internship in the sixth semester in combination with an accompanying seminar, in which the findings from the internship are scientifically reflected by linking them with the basic theoretical trainings
- Writing the second bachelors' thesis in the sixth semester on a topic that is closely related to the student's internship

In the masters' programme "Health Promotion and Human Resource Management" the student groups are characterized by a high diversity. Different (health) professional groups with different educational backgrounds come together within the study programme. By using "study letters", the students are brought to approximately the same level – in terms of previous knowledge relevant to the study programme. Depending on their previous education, applicants are required to catch up on certain subject areas in the form of self-study by using the "study letters".

The masters' programme curriculum also includes many elements of working on topics that are relevant for practice. Students are enabled to gain practical experience in their current or future field of work in a timely and comprehensive manner and to introduce questions from the professional field in the teaching and learning process, as well as to acquire the competence of working in a project-like manner, which is highly important in the professional field. Due to the interdisciplinarity in the health promotion sector, cooperation and collaboration between different professional groups are important. In the masters' programme, these take place through the interprofessional discourse of students in the courses, which is particularly encouraged in a separate course "Forum for Innovations and Problem Solving" in the third semester. In this course students have the possibility to talk about their ideas with fellow students and give each other feedback and recommendations.

Potential and Interest

Some of the activities already mentioned, such as the choice of the bachelors', masters' and project thesis topics, give students a development opportunity to realize and further develop their own potential.

In addition, individual potential and interests are considered by giving the opportunity to get diverse certifications. Specifically, students in the Health Department have the opportunity to get certified in the following fields in cooperation with official certification authorities:

- Workplace Health Management
- Occupational Safety
- Quality Management

- Risk Management
- Project and Process Management
- Nordic Walking
- SAP – Digital Health

In the masters' programme Health Promotion and Human Resource Management, students also have the opportunity to use their individual potential and focus on their interests within the course "Self-organized course". This course has a high degree of student participation, whereby students, with the permission of the course director, define their own curriculum in addition to already established study content.

Learning Methods and Communication Channels

As far as the learning process is concerned, students have individual needs, learning speeds and rhythms. Particularly in part-time study programmes, it is important to provide space for individual learning approaches and to use a variety of communication channels and paths.

In both health promotion programmes at the University of Applied Sciences Burgenland, teachers respond to these different learning approaches and communication needs with different communication channels and didactic methods:

- *Combining different course types* (e.g. integrated courses, management techniques, lectures)
- This allows focused, active and comprehensive teaching, in which the jointly designed learning process (group-dynamic effects, teamwork) is a central element in the transfer of knowledge and the arousal of enthusiasm.
- *Use of innovative didactic methods within classroom teaching*
- The use of various didactic methods should promote orientation knowledge, independent work, self-reflection, communicative competences and the ability to act. Project work, case studies, role-plays, presentations, discussions and short statements are integrated in classroom teaching. An especially innovative didactic method used within the individual face-to-face coursework of the so-called Centre for Management Simulation is the implementation of business simulations. These simulations give students the opportunity to experience group dynamic processes and their effect on organizational efficiency. At the "Centre for Management Simulation", students are able to observe and reflect on their leadership as well as team behaviours. There are six different business simulations. The simulations help to reduce complexity, create problem-oriented learning environments and actively involve students in the learning process.
- The use of digital media is also getting more and more important. The multimedia offerings for classroom teaching range from smartboards to subject-specific software and various learning tools.
- *Distance learning elements*

- Partly due to the recent COVID-19 pandemic, distance learning elements are getting more and more important. These require a comprehensive transformation regarding the design, explicitly the digitalization of teaching and learning concepts. More details concerning this aspect can be found in a separate section of this paper (see Chap. 4).

Linking Teaching and Research

Due to the requirements for health promoters, linking teaching and research is a central didactic model in the Health Department at the University of Applied Sciences Burgenland. Linking teaching and research means that students should be encouraged to reinterpret and evaluate knowledge acquired during their studies and to develop new ways of thinking. In addition, it is important to make students aware of the adherence to scientific standards, the handling of risks and responsibilities in the respective areas.

The didactic basis for the close linkage between theory and practice within the health promotion study programmes at the University of Applied Sciences Burgenland is a concept according to Mick Healey (2005) (see Fig. 27.2).

According to Healey (2005), four potential ways of linking teaching and research are considered:

- *Research-tutored* – engaging in research discussions.
- *Research-based* – undertaking research and inquiry.
- *Research-led* – learning about current research in the discipline.
- *Research-based* – undertaking research and inquiry skills and techniques.

As Fig. 27.2 shows, the four fields of linking research and teaching result from the interplay of the students' level of activity (students as audience vs. students as participants) and the aspect of research under consideration (research content vs. research methods and problems).

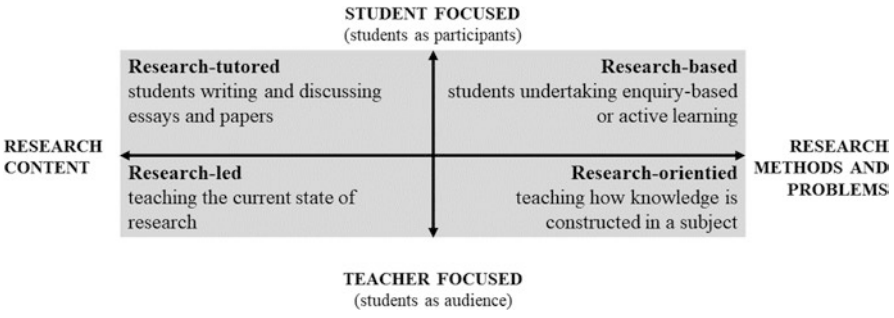

Fig. 27.2 Fields of linking teaching and research according to Mick Healey (2005)

Research-Led Teaching

Within research-led teaching, teachers in the health promotion study programmes at the University of Applied Sciences Burgenland present their own research projects. Students have the opportunity to see how theoretical knowledge can lead to real research projects. In this process, students are taught not only success factors but also challenges and lessons learned that were identified within the research projects.

In addition to presenting and critically examining research projects in individual study courses, teachers and researchers in the Health Department at the University of Applied Sciences Burgenland also developed a course book in the field of health promotion (Gollner et al., 2018). This provides further insights into the interlinking of theory and practice. In the second section of the book, various health promotion projects in different settings are presented, whereby great importance was attached to the presentation of evidence-based and theory-guided approaches. In addition, discussion questions at the end of each project description help students to reflect and critically evaluate the research project.

Research-Oriented Teaching

The development of scientific competences of students already begins in the first semester of the bachelors' programme Health Promotion and Health Management. After a basic course on "Scientific work", the second semester provides a first insight into empirical research methods. At this point, students already apply what they have learned to a subject-specific topic within an inter-course seminar paper. In the following semesters, specific focal points are set around the topic of "Methods in Health Sciences". Scientific and research competences and attitudes are further strengthened within the two bachelor theses students have to write. In the consecutive masters' programme Health Promotion and Human Resource Management, one's focus also lies on the acquisition of scientific competences.

In addition, an online course was recently designed within the Health Department of the University of Applied Sciences of Burgenland, in which the most important contents of scientific work are taught. This is available to all students – regardless of the semester and study programme – and is intended to deepen and expand their skills in the area of scientific work and social science methods. It is designed in such a way that students first have the opportunity to reflect their own academic skills within a self-test. Based on the results of the self-test, students realize in which areas of scientific work or social science methods it makes sense to expand their skills. Overall, the course consists of ten learning modules, each of which contains instructional videos, scripts and informational materials as learning contents as well as quizzes and learning objective checks as learning activities. In addition, the online course includes:

- An introductory video on scientific thinking.
- A forum with announcements, which serves primarily to communicate updates.

- A discussion forum, which offers the opportunity to ask questions.
- Guidelines, templates and literature recommendations for further study.

There are learning objectives for each module. The concrete formulation of these was done by taking into account the taxonomy levels according to Bloom (1976). According to that, descriptive verbs were selected, which on the one hand facilitates the description of the learning objectives and on the other hand makes it possible to check the achievement of the actual learning objectives.

Research-Tutored Teaching

In the bachelors' programme Health Management and Health Promotion and in the masters' programme Health Promotion and Human Resource Management, research-tutored teaching goes far beyond supervising students in writing their seminar papers, bachelors' theses, project papers and masters' theses. They are supported in presenting their research findings to the public health community. Therefore, they are encouraged to present their work at scientific conferences and congresses. The teaching and research staff support the students throughout the entire process, from submitting abstracts to preparing for the presentation. In addition to the presentation of research results at congresses and conferences, students also get the opportunity to publish their findings from their bachelors' or masters' theses in the form of articles in research volumes. In the new volume published by the Health Department at the University of Sciences Burgenland called "COVID-19 – A multi-perspective view of the pandemic" (Gollner & Braun, 2021), students were also able to contribute their expertise gained from bachelors', masters' or project theses on various health science aspects of the COVID-19 pandemic.

Research-Based Teaching

Students in the bachelors' programme "Health Management and Health Promotion" are involved in real research projects in two ways:

- Students participate directly in work packages of ongoing research projects at the University of Applied Sciences Burgenland within different courses (e.g. "Health Promotion Practice Project").
- Students work on individual topics of ongoing research projects at the University of Applied Sciences Burgenland as well as in other cooperating institutions in the health sector within their bachelors', masters' or project theses.

Knowledge Transformation Process

Due to the COVID-19 pandemic and the accompanying restrictions, there have recently been significant changes at Austrian universities. These made it necessary to undergo a digital transformation in higher education teaching and didactics. Specifically, it was necessary to revise teaching concepts and convert them to online-based or hybrid formats. In the Department of Health at the University of Applied Sciences Burgenland, it was important:

- To continue implementing the concepts explained in the previous sections (see Chap. 2) as much as possible.
- To stick to the didactic principles explained in the previous sections (see Chap. 3).
- To use both the concepts and the didactic principles as valuable resources within the transformation.

To meet the demand for high-quality and person-centred teaching, a concept for the implementation of distance learning methods and hybrid forms of teaching was developed, and an individual support offering for lecturers was created. In this context, already existing approaches that are included in the personalized teaching and learning strategy of the University of Applied Sciences Burgenland could be used. Even before the pandemic, three learning phases were linked within hybrid teaching:

- *Face-to-face teaching*
- *Online teaching*
- *Self-study*

Although online teaching supplemented face-to-face teaching and self-study even before the pandemic, it was not to the extent to which is currently required. In the bachelors' programme, teachers were required to switch from almost exclusively face-to-face teaching and in the masters' programme from 2/3 face-to-face teaching to almost 100% distance learning. This presented big challenges for both teachers and students. For this reason, a concept was developed within the department to support teachers in designing didactic concepts using digital tools and media. Subsequently a three-part offering was put together for teachers (Braun et al., 2021):

- *Competence Enhancement*

- A free training and certification programme is available for teachers to strengthen their subject and methodological competence in the areas of eDidactics, distance learning and hybrid teaching and learning arrangements.
- *Collection of Tools and Methods*
- Digital and technology-based knowledge transfer and collaboration can only succeed through the adequate use of digital tools and methods. The Health Department has developed a method kit for this purpose, which teachers can access via the Moodle platform used in the department.
- *Support*

- A support team in the Health Department is available for questions and suggestions on the topic of eDidactics. Teachers are supported and advised in the development and implementation of their didactic teaching concepts.

Although distance learning elements had already been integrated into individual courses before the pandemic, they were mostly asynchronous. In the sense of personalized teaching, these were intended to allow students greater flexibility in terms of time and place with regard to the design of learning processes. Due to the required conversion of teaching to almost 100% distance learning, it was also necessary to create a basis for synchronous teaching and learning phases in which students work together interactively on course contents. In almost all courses, there was a combination of asynchronous to synchronous distance learning units. The former were mainly carried out via various working materials and activities on the Moodle platform and the latter via MS Teams, a video conferencing tool. Within video conferences, virtual group work functions, various voting tools and online whiteboards were also used.

In addition, online self-learning courses were created, which enable students (but also teachers) to deal with selected teaching content individually, independent of time and place. The online self-study course on the topics of scientific work and social science methods pursues the following goals:

- Students have the opportunity to reflect on and deepen their scientific skills and to prepare themselves individually for scientific work.
- After courses on the topics "Scientific work" and "Social science methods", students have the opportunity to further deepen their knowledge in individual subject areas.
- Teachers in the Health Department can use the self-learning course as an asynchronous distance learning element in addition to face-to-face teaching and synchronous distance learning.
- Supervisors of academic theses can focus on content-related supervision.

Reflection

Regarding content of the study programmes Health Management and Health Promotion and Health Promotion and Human Resource Management, the CompHP Core Competencies Framework for Health Promotion and the outlines of a new health education policy are the basis. They provide guidelines with regard to the definition of learning objectives and competencies to be acquired.

The personalized teaching and learning strategy of the University of Applied Sciences Burgenland and the concept of linking teaching and research offer teachers a didactical framework in which concrete course concepts can be developed.

The information and explanations in this paper show that linking teaching and research represents an important didactic principle of the two study programmes. On the one hand, research results are transferred into practice; on the other hand, the

focus is primarily put on the critical reflection of the research process and the methodological procedure within a research project. As a result, students – especially at masters' level – learn not only how to work on a research problem but also how to work on it in relation to their own professional context. Experience shows that especially the latter aspect is very valuable for new career paths in health promotion. Research-led teaching is especially meaningful, where it is supported by evidence- and theory-based professional health promotion.

Due to the COVID-19 pandemic, the Health Department at the University of Applied Sciences Burgenland was faced with challenges concerning implementing content-related and didactic concepts primarily in the form of hybrid or online-based teaching and learning arrangements.

- In order to ensure high-quality health promotion and face new challenges, the use of the didactic principles is continuously evaluated. Therefore face-to-face and virtual feedback rounds with students after each semester, regular course evaluations (standardized questionnaire including questions concerning organization of the tuition, course content, tutor, overall impression, personal assessment, infrastructure and "open" feedback) and teacher questionings (standardized questionnaire) take place.

At the end of the winter semester 2020/2021, teachers in the Department of Health filled in a questionnaire concerning success factors and challenges within distance learning. The results were used to develop the three-part offering mentioned in Chap. 4.

The experiences clearly show that teaching content cannot be transferred 1:1 from face-to-face to distance learning settings but that it must be carefully considered how synchronous and asynchronous teaching and self-study periods should be combined to reach the learning goals. Another question is which instruments and tools are helpful. In many courses, inverted classroom techniques have been very successful. Students first developed course content independently, which they then deepened and reflected with their teachers within synchronous distance learning units. This understanding of teaching presupposes that all participants know their role and exert it. Teachers give professional impulses and promote the students' ability to reflect. Students, on the other hand, are not mere consumers anymore but active learners who transfer their acquired knowledge and competences to their own professional context.

Universities before COVID-19 will not be the universities after COVID-19. This virus has led to a reset of higher education didactics like no other event in recent decades. "Social distancing" required "virtual learning". The disruptive change that gripped the university makes it possible to turn the crisis into an opportunity for new university teaching adapted to the digitized world with hybrid and mutually complementary teaching formats.

However, it is necessary to take into account that digital teaching cannot compensate for everything. For example, "non-academic" aspects of student life such as personal contacts and mutual support are missing. This can have a negative impact on the overall learning experience. A survey conducted by the Stifterverband 2020 among students in Germany found that the lack of social interactions leads to

negative psychological stresses such as fears about the future, motivation problems and a persistent feeling of insecurity (Winde et al., 2020).

Experiences during the COVID-19 crisis show which transformation processes can point the way to higher education didactics in future, and universities have to create the organizational framework for this:

- Digital teaching concepts will make up an increasing part of university teaching in the future. They will not displace face-to-face teaching but complement it. It will be crucial to develop subject-specific teaching strategies that are adapted to the needs of teachers and students.
- When designing online courses, attention must be paid to the type of course. In lectures with a larger number of students, an appropriate mix of synchronous and asynchronous teaching units can make it possible for students to learn independently of time and place, away from disadvantages of present "mass teaching". In teaching formats with very small groups, such as seminars, management techniques or exercises, interaction in face-to-face teaching units can increase the learning quality.
- If the future for students consists of a mix of online and face-to-face teaching, higher education institutions will be called upon to make greater use of the strengths of both teaching formats. For example, bachelors' or masters' theses supervision can take place more intensively via digital formats. The acquisition of theoretical knowledge can take place in the form of self-study and asynchronous teaching, while classroom teaching can be used more for reflection and discussion. Due to the combination of online and face-to-face teaching, students will spend less time on campus. Universities should therefore consider how to create social meeting and interaction spaces on campus.
- Digital skills are "future skills". This applies to teachers and staff at universities as well as to students. There should be more offerings concerning teachers' further training on the didactic implementation of hybrid teaching. Doing so can motivate them to integrate appropriate online elements in their courses. The COVID-19 crisis showed how important digital skills are in all fields. These "future skills" should be a part of the curriculum because they will be of decisive importance for professional life and social participation in all sectors in the coming years (Winde et al., 2020).

The Health Department at the University of Applied Sciences Burgenland has developed programmes that support teachers and students in providing hybrid teaching at a high level of quality and adapted to the needs of teachers and students. For example, the didactic online method kit is continuously filled with new tools. Self-learning courses, which students and lecturers across all study programmes can use, are being further expanded. The regular use of evaluation tools forms the basis for continuous growth.

The COVID-19 crisis has enormously "boosted" higher education didactics. This makes it possible to develop and implement an "up-to-date" higher education teaching strategy, which in turn makes it possible to teach students urgently needed

Table 27.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Our vision is that health promotion takes place on three different levels: individual/personal level (health behaviour), structural level (healthy environment) and system level (in order to reach sustainability). We conduct projects in all settings and try to make deductions across settings
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	The Department of Health at the University of Applied Sciences Burgenland offers a variety of university degree programmes focusing on health promotion, which is unique in Austria. These programmes include: A six-semester bachelors' degree programme in health management and health Promotion (full-time) A consecutive masters' programme in health promotion and human resource management (part-time) A second consecutive masters' programme health management and integrated care (part-time) Two six-semester health profession study programmes health care and nursing and physiotherapy Erwin Gollner: Head of the department "health", profession – Psychology, sports science Barbara Szabo: Lecturer, profession – Health sciences, health promotion, health management Florian Schnabel: Head of the study programme health promotion and human resource management, profession – Sociology We try to implement our research experiences both in teaching and consulting (workplace health promotion) and vice versa The bachelor's degree programme health management and health Promotion is the only one in Austria which focuses on health promotion
Which theories and methodologies are used in the teaching-learning process?	As described in our chapter Didactic principles: Personalized teaching and learning, linking teaching and research Within the knowledge transformation process: Combining face-to-face teaching and online teaching (synchronous, asynchronous)

(continued)

Table 27.1 (continued)

Questions	Take-home messages
What kind of forms of assessment are applied, results achieved, and challenges faced?	Due to the COVID-19 pandemic, the health Department at the University of applied sciences Burgenland was faced with challenges concerning implementing content-related and didactic concepts primarily in the form of hybrid or online-based teaching and learning arrangements In order to ensure high-quality health promotion and face new challenges, the use of the didactic principles is continuously evaluated. Therefore face-to-face and virtual feedback rounds with students after each semester, regular course evaluations (standardized questionnaire including questions concerning organization of the tuition, course content, tutor, overall impression, personal assessment, infrastructure and "open" feedback), and teacher questionings (standardized questionnaire) take place At the end of the winter semester 2020/2021, teachers in the Department of Health filled in a questionnaire concerning success factors and challenges within distance learning. The experiences clearly show that teaching content cannot be transferred 1:1 from face-to-face to distance learning settings but that it must be carefully considered how synchronous and asynchronous teaching and self-study periods should be combined to reach the learning goals. Another question is which instruments and tools are helpful. In many courses, inverted classroom techniques have been very successful The University of Applied Sciences is multiple-certified (www.fh-burgenland.at)
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	Framework: CompHP Core competencies framework for health promotion, outlines of a new health education policy in the DACH region (including Germany, Austria and Switzerland)
What could others learn with your experience? What is localized and what is "generalizable"?	We think that combining research, teaching and consultation experiences within health promotion is an important key for success. Also deductions across settings are very gainful Universities before COVID-19 will not be the universities after COVID-19. This virus has led to a reset of higher education didactics like no other event in recent decades. "Social distancing" required "virtual learning". The disruptive change that gripped the university makes it possible to turn the crisis into an opportunity for new university teaching adapted to the digitized world with hybrid and mutually complementary teaching formats During the COVID-19 pandemic, using a variety of didactic principles and creating a concept for the implementation of distance learning methods can help meet the challenges during the knowledge transformation process. Results may be referred to a wide range of study programmes in various academic fields

"future skills", from indispensable social skills to a variety of subject-related competences.

Table 27.1 discusses our reflection on the six triggering questions suggested by the editors.

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Chapter 28
Health Promotion and Integrative and Complementary Practices: Transversality and Competence Development in an Undergraduate Experience

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Contents

Introduction

Incorporating health promotion into the set of academic content presents a challenge for educators that dedicate themselves to professional training, notably in undergraduate health courses; and the paths that we have experienced to respond to this challenge motivated us to share, in this chapter, the lessons that resulted from the experience of carrying out the course "Integrative and Complementary Practices

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in Public Health Care," offered to the undergraduate courses of the Institute of Health and Society at the Federal University of São Paulo (UNIFESP), Baixada Santista Campus. The course was discontinued in 2020 due to the COVID-19 pandemic and is scheduled to resume in 2022.

In a first stage, and before addressing the experience itself, we describe the scenario in which it is inserted: health promotion, as an intersectoral field[1] of knowledge and practices, aims at empowering and giving the populations control on their health conditions and well-being, to guarantee the conditions for the full realization of everyone's human potential (WHO, 1986); traditional and complementary medicine, as a field that encompasses traditional medicines from different cultures and a diversity of health care that has, as a common principle, the intention of fostering natural mechanisms for disease prevention, recovery, and health promotion (WHO, 2013); and the pedagogical political project of UNIFESP, Baixada Santista (UNIFESP, 2006), guided by the principles of interprofessional education (WHO, 1988).

Transversality, understood as a crosscutting integration feature, considers the potential of compositions between the fields of knowledge and practices and of integration of theoretical knowledge and actual life issues, rooted in a historical, social, and cultural context (Pedroso & Vieira, 2009).

Transversality is part of the expansion that follows the evolution of health promotion in the process of overcoming the conceptual model of the 1950s, when it was limited to the first level of health prevention (Leavell & Clark, 1976). This transformation, marked by the Lalonde Report (1974) and the Alma Ata Declaration (WHO, 1978), establishes the foundations of the contemporary concept of health promotion in the Ottawa Charter (WHO, 1986) comprising assumptions and five areas of action that require commitments from states, health systems, communities, and individuals, expanding the responsibilities hitherto restricted to the health sector, as well as fostering the perspective of overcoming the biomedical health model, based on disease and curative assistance (Buss et al., 2020). The guidelines produced at subsequent world conferences showed the way of deepening and unfolding these assumptions, according to experiences from different local settings, until reaching the Shanghai Charter (WHO, 2016), which establishes the commitment of health promotion policies to the Sustainable Development Goals of the 2030 Agenda.

The Traditional and Complementary Medicine (T&CM) or Integrative and Complementary Practices (PICs)[2] are holistic modalities of health care that are part of the culture of people from different regions of the world. These modalities are constituted by deeply rooted traditional health-care concepts and practices, both philosophically and culturally; complementary practices that do not belong to the conventional medicine but are adopted by the population; and the perspective of producing integrative approaches with conventional biomedical medicine. The

[1] Field is understood, in this chapter, in the dynamic sense of the relations between the production of symbolic goods, intellectual production, and the relations of power (Bourdieu, 1971).

[2] We chose to limit ourselves to the nomenclatures adopted by the WHO and the Brazilian state, respectively.

integration of these practices in national health systems, also highlighted in the Alma Ata recommendations, has been recommended by the WHO since 2002 with hallmark documents, such as the Traditional Medicine Strategy 2002–2005 and the Traditional Medicine Strategy 2014–2023, and the challenges for their development are related to the acceptance, dialogue, and coexistence between these medicines and the biomedical model added to its diversity. The main goals for the period from 2014 to 2023 include the integration of its practices with health services and self-care in promoting universal health coverage (WHO, 2013). Recommendations issued to member states encompass the development of national policies, integrated or not with other existing health policies (WHO, 2019).

The potential approximation between these medicines and health promotion is especially linked to holism and involves the development of personal skills, the values of solidarity that are essential to community action, and the reorientation of health systems and their epistemological basis, because "both movements recognize the multidimensional and indivisible nature of 'being', and its social and environmental determination" (Franco de Sá et al., 2019, p. 74).

In Brazil, this approach is enabled by public policies, aligned with the guidelines and the network operation of the Unified Health System (SUS). According to Franco de Sá et al. (2019), both converge on principles and values and contribute to strengthen and to add complexity to the SUS model and praxis. On a practical level, convergent actions were produced until 2020 through interprofessional working groups, the Family Health and Primary Care Centers, whose continuity is currently uncertain (Buss et al., 2020; Ministério da Saúde 2020). In general, the potential for dialogue between the two is still little explored (Tesser, 2009).

Even though these types of medicine are present worldwide, the training of culturally competent health professionals in health promotion is still a global challenge (Smith & Pérez, 2021).

The Teaching of PICs in Brazil

Even though the political and institutional frameworks of PICs in Brazil are advancing at the pace of international guidelines, public investments are scarce and professional training is insufficient, especially in public universities. These universities were historically the places that defended the right to health based on SUS values. In addition, training in T&CM or PICs is long and expensive (Nascimento et al., 2018). The Chinese, Ayurvedic, homeopathic, and anthroposophic medicine training courses are offered at the postgraduate level by private institutions, aimed at the middle and upper classes consumer market, and only 32.3% of public higher education institutions deal with T&CM and PICs in their health curriculum, with emphasis on the nursing course (25.4%), followed by medicine and physiotherapy (Salles et al., 2014). Research in a regional level shows that most of these courses are optional. Even without the purpose of training, the introduction of PICs in undergraduate courses aims at the promotion of the epistemological openness to allow

"inhibiting common sense prejudices, emphasizing communication skills, establishing a relationship with patients, and comprehensive care approach," as well as to "encourage the debate on different conceptions about the nature of the disease, the importance of the individual in the therapeutic effect, the breadth of care" (Nascimento et al., 2018, p.764).

The Pedagogical Political Project of UNIFESP's Institute of Health and Society is guided by the principles of interprofessional education and integration with the community (community-oriented). These principles are the basis for learning the necessary skills for professional performance. The approach of crosscutting issues takes place in a modular curriculum structure, favoring the construction of health knowledge that privileges primary care (WHO, 1988). In this structure, the specific thematic axes of each profession and those that are common to the various courses are articulated, and both incorporate health promotion into studies and practices (UNIFESP, 2017). Along these same lines, the curricular matrix of the UNIFESP's Occupational Therapy Course incorporates ways of working with the body, emotions, communication, and social and cultural values into the cognitive content (Jurdi et al., 2018).

Integrative and Complementary Practices in Public Health-Care Course

In this context, the course was implemented in the curriculum in 2019 in UNIFESP's Institute of Health and Society and was offered as an elective subject by the Occupational Therapy Undergraduate Course to students of that course and also Physical Education, Physiotherapy, Nutrition, Psychology, and Social Work undergraduate students. The duration was one semester, with a workload of 80 hours, divided into 40 theoretical and 40 practical hours; and it was coordinated by two professors, from the Occupational Therapy course and the Common Axis.

The general objective was to present integrative and complementary practices in the context of production and management of individual and collective care in public health facilities. The theoretical content was guided by the concept of Medical Rationalities in Health (Tesser & Luz, 2018) and by SUS principles. The premises of multi-professional education, characterized by active methodologies (learning by doing) and collaborative learning (Cavalcante, 2018), were combined with methods of somatic education and contemplative pedagogy.

The integration with the community happened through the participation of lecturers who work with the PICs in the public primary care network, in community spaces, in an indigenous village, and in an extension program to the community of the university itself (called "Meditating on campus," *Meditando no campus* in Portuguese), who were invited after being identified on a previous survey in the region.

The course was composed of 15 care modalities: 10 of which were programmed based on the resources already existing in the region, while 5 were chosen by the students, researched by them through a previous script and presented in theoretical-practical seminars. Table 28.1 summarizes this composition.

The classes' dynamics consisted of an experiential part, a theoretical part, and conversation roundtables. As a suggestion from students, a community snack break was offered. The participant evaluation was continuous, resulting in two products: the theoretical-practical seminars, created in groups, and a reflexive self-assessment at the end, with three guiding questions: (1) perceived affections (more intense or striking aspects); (2) reflections on the process (description of the learning path experienced); and (3) activation of the movement (what they would like to propose differently and what was missing from the course).

In the following section, we reflected on the students' comments, based on the final self-assessment produced by 25 students, in dialogue with the theoretical and methodological choices of the course and reflections of the teachers during the process.

Contacts Among Different Medical Rationalities: Sensitivity and Cultural Competence

The course proposal aimed at sharing reflections based on contextualized presentations and experiences of each approach, beyond the techniques.

To that end, we adopted the concept of medical rationalities, a method that allows an approximation of health knowledge and practices in different cultures, through five interconnected dimensions: human morphology, vital dynamics, diagnosis system, therapeutic system, and medical doctrine, all of them based on cosmology, a set of senses and meanings which enables the apprehension of reality in each culture (Tesser & Luz, 2018).

Throughout the course, the contact with conceptions of life and health from different traditions provoked reflections on the boundaries of such conventional biomedical model in understanding the health-disease-care process, as suggested in the example below:

> I believe that this course should be mandatory in the graduation of all careers, since we were able to break away from the biomedical view of training, which is a characteristic of the campus, and we were able to see other ways of care. [student G].[3]

The student's observation highlights a broad epistemological problem related to the health field since the production of knowledge and technical development in this field is based on the concept of disease. Some paths for a conceptual and strategic reorientation have been formulated initially by the Ottawa Charter (1986), such as the following: "Health is a positive concept which emphasizes social and personal

[3] All the student's texts were translated by the chapter's authors.

Table 28.1 The teaching plan

Class	Subject	Staff/guest lecturer	Place
1	Presentation/medical rationalities in the contemporary world	Two professors from UNIFESP/course	Therapeutic resources laboratory (TRL)
2	Circular dances	Two occupational therapists from SUS: Primary care unit and coexistence and cooperative center, both certified in circular dances	Gym room
3	Yoga	A professor from UNIFESP/course, certified in yoga	Gym room
4	Meditation	Four students from UNIFESP: Extension project "meditating on campus"	TRL and collective spaces in the campus
5	Tai chi and Chinese medicine	A physical education teacher from SUS: Municipal health department, a specialist in Chinese medicine and tai chi chuan	Gym room
6	Acupuncture, auriculotherapy, and Chinese medicine	Two occupational therapists from SUS: Basic healthcare centers and psychosocial care center, both are specialists in acupuncture and auriculotherapy	TRL
7	Parental techniques: Shantala massage, Ofuro bathing practice, baby-wearing sling, and pain management during pregnancy	Two physiotherapists from UNIFESP/a professor and a doctoral student specializing on anthroposophy	TRL
8	The use of medicinal plants in an indigenous community	The representative of traditional medicine of Tupi-Guarani people from an indigenous community in the territory	TRL
9	Preparation of theoretical-practical seminars	Student workgroups	Off-campus group activities
10	Theoretical-practical seminars,integrative community therapy, phytotherapy, reiki, aromatherapy massage	Student workgroups and professors from UNIFESP/course	TRL
11	Integrative practices in occupational health contexts	A physiotherapist from UNIFESP/collective physiotherapy project and two heads of sector from the municipal health department	Offices and a public square
12	Therapeutic approaches about the touch	A professor from UNIFESP/course, certified in eastern and Western massage	TRL
13	Self-care and health promotion	Two professors from UNIFESP/course	TRL

(continued)

Table 28.1 (continued)

Class	Subject	Staff/guest lecturer	Place
14	Conclusion	Two professors from UNIFESP/ course	TRL
15	Final evaluation	Two professors from UNIFESP/ course	TRL

resources, as well as physical capacities", and "Caring, holism, and ecology are essential issues in developing strategies for health promotion" (WHO, 1986, para. 3). This reorientation was deepened from that time on, until the Shanghai Declaration (2016), which defined health as "a universal right, an essential resource for everyday living, a shared social goal and a political priority for all countries" (WHO, 2016, p. 5).

Despite this reorientation, the difficulties in distinguishing between prevention and promotion in health practices manifest in the Brazilian context by the persistence of normative and verticalized conducts. These are aimed at prescribing healthy lifestyles, neglecting the ways of life experienced in people's daily lives:

> The development of scientific, and particularly medical rationality brought enormous power to bear on constructing representations of reality, in disregard of one fundamental consideration: the limits of concepts concerning reality. In health, such limits are those of the health and disease concepts vis-à-vis the current experiences of health and illness. (Czeresnia, 1999, p. 702).

Changing cultural patterns rooted in the field of health is slow, complex, and procedural. Within the limitations of this course, the intention to contribute to this transformation was reflected in the methodological choice, through the combination of experience, theory, and dialogue in an environment of horizontality.

The presentation of the theoretical content was mediated by the experiences of work and living with a biomedical model, brought by the guests. The compositions between the PICs and the conventional work modalities of these services indicated paths for the renewal of conventional conducts in health promotion and care:

> I believe that the highlight of the course was to have enabled us to practice what we heard in theory, together with guests with experience in the subject. I feel that I got involved with the practices and that it was valuable for my personal and professional growth. [Student T].

Some traditional practices were included in the course, even though they were not yet incorporated into SUS, based on the premise that addressing Brazil's ethnic issues in professional training requires training for intercultural dialogue, essential for an inclusive performance, based on the recognition and respect for the cultural traditions of peoples who have suffered exclusionary policies and practices throughout the country's history (Ribeiro et al., 2019).

The absence of these practices in the national policy of PICs was highlighted by the students, who also considered that their inclusion in the course is a necessary step for their validation:

> Among the PICs listed in SUS, we rarely see traditional Brazilian practices. I believe that they can gain space and legitimacy as we practice and demonstrate their potential with the communities which we work with. [Student D].

An example is the repercussion of the participation of the Traditional Tupi-Guarani people Medicine representative from an indigenous land in the territory:

> The contact with the Traditional Medicine representative was a very remarkable experience, as he brought knowledge, culture and history that you cannot read in books or learn in conventional classes, he made me reflect a lot regarding indigenous culture. [Student U].

The effects of this initial contact were observed in the subjects that emerged in the conversation roundtable and in the emphasis on the motivation in knowing and respecting the ways of traditional peoples to live, promote, and take care of their health to guarantee equity in their assistance. The contrast between the respectful and sustainable relationships that these people establish with nature was highlighted, as well as the context of the environment destruction which affects everyone and threatens the survival of these populations.

The issues surrounding the living conditions and the health care of Brazilian indigenous populations are complex and deserve more attention than is possible here,[4] but it is worth mentioning that indigenous health care in Brazil is specific for these populations, being concentrated in their villages. Part of this population that lives in urban and peri-urban areas is served by local nonspecific health services (Ribeiro et al., 2019). This context reinforces the need to develop skills for intercultural dialogue at undergraduate level, particularly in health.

Cultural competence can be understood as the set of capacities necessary for interpersonal communication, based on the understanding of cultural differences and the different ways of understanding health, disease, and the body (Whachtler & Troein, 2003).

Holistic approaches to health are present worldwide and are progressively validated by effectiveness studies, but training culturally qualified professionals for health promotion is still a frequent challenge. Understanding the cultural and scientific constructs related to these practices is essential to the quality of care through these practices (Smith & Pérez, 2021).

Given the diversity of concepts and strategies involved in the development of this competence (Gouveia et al., 2019), we will limit ourselves to two points which involve the analyzed experience: recognition of cultural complexity and its consequences in the course development, related to the development of cultural sensitivity.

As a reference for a reflection on cultural competence, we adopt a dynamic understanding of culture, based on the practical convergence between the anthropological and sociological senses, and the usual sense, linked to social practices (Williams, 2008). From this perspective, mutual interactions between systems of meanings and social practices of societies are configured in the communication,

[4] For a greater understanding of this theme, consult Ribeiro et al. (2019).

reproduction, conservation, or transformation of social standards, and each subject is, at the same time, bearer of these standards and producer of cultural facts.

In this perspective, the development of cultural competence requires self-knowledge, as well as the capacity to recognize the other, both with values and behavior patterns, and continuous attention to their influence on communication, as well as the reception of what is communicated by the other.

This cultural dimension and its implications for health-related behaviors are called *cultural humility* by Santana (2018):

> A humble, reflexive approach requires an attitude of respect towards diversity and towards the individuality of cultural experiences and their meanings, including multiple points of view in the design of the therapeutic project. In practice it means, for example, adopting a coordinated combination of treatments offered by the 'official medicine' with those actions offered by popular healers. (Santana, 2018, p.2).

This dimension can be understood as a way of developing culturally egalitarian relations, understood as an ethical quality that implies knowledge of one's limitations, absence of moral judgment, and horizontality in health relationships. From this point of view, cultural competence is revealed in the relationships. Additionally, it implies the development of a self-reflective capacity to identify internal prejudices and to be continuously critical to transform them.

Among other ways, this issue was incorporated into the course through opportunities for self-perception and the perception of the other and fostered by welcoming environments in this process, with support for the content mobilized in the experiences and for the moments that made sharing the experience possible.

The PICs' Teaching-Learning Process: Contributions from Somatic Education and Contemplative Pedagogy to Health Promotion

In the health field, clinical practice methodologies, such as evidence-based practice, are valued within professional training, as they place students in a condition similar to the work they will perform after graduation. Although critical pedagogies in Brazil have highlighted the power relations that exist between teachers, students, and the political dimension of knowledge, this debate is less intense nowadays. Currently, the methodological debate in education highlights active methodologies combined with technology, which "remove the students from a passive role, as they are responsible for their learning process, building knowledge in an interdisciplinary and holistic way" and which provide "an intellectual repertoire and refined skills" (Souza et al., 2020, p.3). Learning to learn is the key idea of these methodologies that transfer responsibility to the students for the educational process. The desired autonomy, which implies self-management while learning, may also be stressful and cause anxiety (Bento et al., 2017).

In the educational field, the emphasis on student accountability comes from constructivist pedagogies. Although it is a valid method in certain educational contexts, it is necessary to remember that the theoretical concerns of the father of constructivism, Piaget, were focused on what is common to all human beings: "Therefore, he was not interested in differences, but in the universal" (Ramozzi-Chiarottino, 1997, p.116).

When considering culture as a privileged aspect of education, it is necessary to assume cultural difference as the guiding dimension of pedagogical processes. In this experience we report, the encounter with different knowledge guided the pedagogical choices. Regarding otherness, the most important thing was to mobilize openings and deconstructions. Through somatic education in contemplative pedagogy, opportunities were created to deconstruct patterns of movements and crystallized behaviors through proposals for self-knowledge, perception, and openness to the other, as well as through the investigation and confrontation of their prejudices, in the perspective of the interplay between the experience of otherness and the development of empathy.

Somatic education brings together a set of methods of sensitive exploration of the body to produce awareness of its conditionings, as well as opening possibilities for less explored perceptions and kinesthesis. Somatic methodologies value direct experience and promote integrative education, in which students are permanently invited to share their subjective perceptions of the body and the learning.

Somatic education is based on the displacement of perspectives: from the *body*, as an object of study considered in the third person, to *soma*, its investigation in the first person. When presenting the concept of *soma*, Green (2002) synthesizes it as an "embodied process of internal awareness and communication" (p. 114), where the idea of process is decisive for the understanding of so-called somatic education. Investigating the body from direct experience means assuming that body knowledge "may be seen as the ways how we understand both ourselves and, at the same time, our environment through the body; it's also the way we build our meaning of the world through bodily experiences" (Green, 2002, p. 114). The theoretical and practical field of somatic education brings together different mind-body therapies and education methods, such as Alexander technique, Feldenkrais, anti-gymnastics, Eutonia, and body-mind centering, among others (Bolsanello, 2011).

The theoretical and practical field of somatic education brings important contributions to make teaching more coherent with the purposes of PICs. As long as the objective of these health practices is to value different knowledge and produce integrative care for people (in the physical, cognitive, affective, and spiritual dimensions), somatic education provides methodological guidelines that are especially significant to embrace these dimensions in the scope of teaching, providing a coherent alignment between health and education purposes.

The so-called contemplative pedagogies employ a wide repertoire of practices: "silent sitting meditation, compassionate practices, walking meditation, deep listening, mindfulness, yoga, calligraphy, singing, guided meditations, nature observation, self-inquiry and many others" (Grace, 2011, p. 99). Through them, students are invited to scrutinize themselves during the act of learning, an investigation that

mobilizes sensations, affections, and memories to intensify the relationship between what is knowledgeable and what is known (Barbezat & Bush, 2014).

Based on these methodological references, the teaching-learning process was experimental, guided by experiences in a laboratory that is scarcely explored at the university: the body itself. The spaces suitable for experiencing one's own body are in short supply at the university; therefore, body experiences were produced in adapted spaces: a therapeutic resource room for occupational therapy with various materials (mattresses, fabrics, stationery) and support structures (sinks, tables); a gym with a stereo; and alternative spaces (such as corridors).

In the students' narratives, the most remembered classes were of the practical type, with reports of the importance of "experiencing what I was learning" [student J], with "learning through the body" [student L] being especially striking. Some students emphasized that not only was the methodology differentiated but also its results: "unlike other modules, [the learning process] was basically done by the body, something I greatly appreciated, as I was literally able to 'incorporate' the idea of the module and the importance of PICs" [student D].

Finally, some other interviewees narrated the subjective aspects of bodily experiences with yoga, dance, meditation, or massage intensively. Such narratives are presented as "revelation," "awakening," or "recognition" of senses and feelings, most of the time understood as a process of self-care and self-knowledge.

Some practices already known to students were reframed: "Yoga was something I had tried to practice, but it always had something uncomfortable, it was not pleasant, and in the end, I gave up. But with the guidance of the teacher, my perspective on Yoga was changing" [student U]. "I was able to see my body quite focused on the proposed movements, an unusual situation since I had never been able to do meditation without dispersing or finding it boring" [student W].

In addition to the process of deconstructing negative experiences, voluntarily abandoned by the aversion generated by past experiences, there were also narratives about rediscovering already known practices, caused both by the technical and critical development of the gaze and by the attitude of curiosity, less susceptible to common sense judgments or by the dominant epistemological norm, even leading to the incorporation of practices and therapies into personal and professional life:

> I was able to try practices such as Yoga, Circular Dance, and Meditation, which I already knew, but now with different eyes. Not just a technical look, but a look marked by curiosity. Meditation has become part of my weekly routine. [student D]

Among health service users, the effects of PICs are similar. According to Antunes (2019), in addition to integrative body practices that are effective in health complaints, changes in behavior and perceptions of health and disease processes are evident, both at the individual and collective levels. In analyses developed on the experience of users of PICs, the author considers that "the experience with body movements was the integrating unit of a sensitive and reflective work that enabled people to reconstruct relationships with issues associated with illness, malaise and self-care" (Antunes, 2019, p. 8).

The beneficial lightness of the classes at this content unit caused a critical strangeness and deconstructed patterns of normality of the demands experienced in the academic routine, characterized as exhausting, heavy, and tiring. In a sentence: "nothing needs to be too hard or unpleasant for it to be effective. The deconstruction was intense and internal" [student Q].

The reports indicate that the experience of learning with the body shifts the scientific boundaries between subject and object. While narrating their experiences, students are the subjects apprehending yoga, but they are also apprehended by yoga, that is, the border field of body experience in integrative practices blurs the boundaries between being an agent and being a patient, between contemplating and acting, as well as between the limits of the subject, method, and object.

Final Considerations

This assessment shows that the results of the crosscutting approach refer to the development of cultural competences, stimulated by contact with the meanings attributed to life and health in different cultural traditions; to relational skills, improved by the moments of coexistence in the context of the course, by the heterogeneous profile of the students, and by the group activities; as well as to the comprehensive development of students, in the cultural, physical, affective, cognitive, and interpersonal sense, through experiential activities.

From our point of view, these results are related to variables such as the university's pedagogical project, which gives value to interprofessional education and integration with the community; the diversity of professionals who practice traditional and complementary medicine in this territory; and the repertoire of the teachers themselves, joining academic and non-academic knowledge. These are local variables.

In the global context, the conditions to produce crosscutting approaches are given by the WHO recommendations and by the finding that, although complementary medicines are expanding worldwide, the development of cultural skills for health promotion still does not keep pace with this growth.

As a local approach, we may share initiatives to bring teachers closer to the local reality, as drawn from our experience, as well as the articulation of partnerships with the community, to bring popular knowledge and practices into the academic environment. Finally, we found it of interest to share the somatic approaches, for their potential to contribute to the integral development of students.

Health promotion implies overcoming epistemological barriers that keep health education restricted to conventional curative medicine, which is hegemonic in most countries. In our view, this is a global challenge, which requires solutions according to local variables. We hope that this experience report can inspire new initiatives.

Table 28.2 brings our reflection on the six triggering questions suggested by the editors.

Table 28.2 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion (HP) is understood as an intersectoral field of knowledge and practices that aims to encourage populations to deal with their health conditions and Well-being to guarantee the conditions for the full realization of everyone's human potential. The conjunction to theoretical knowledge and actual life issues, according to each historical, social, and cultural context, is presupposed in the five fields of action of the Ottawa Charter (1986) and requires commitments between governments, health systems, communities, and individuals As health professors at the public university, we promote the training of personal skills, the experience of otherness, and the development of empathy that are essential to community action, aiming at the sustainability and humanization of health care. Emphasizing sensitivity and cultural competence, we take interdisciplinary and transversal approaches to enhance relationships between HP, specific professional training, and training in holistic practices
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	We analyzed an undergraduate discipline that brought together health promotion and integrative and complementary practices developed at the Federal University of São Paulo, Baixada Santista campus (Brazil), within an interdisciplinary pedagogical project for training health professions. The course was elective and interdisciplinary, coordinated by two professors of occupational therapy and physical education, and had guest speakers from the public health network, from community spaces, and from an indigenous village. It was developed in 2019, with a duration of one semester and a workload of 80 hours, 40 of which were theoretical, while the rest was practical. Twenty-five students participated in the course
Which theories and methodologies are used in the teaching-learning process?	Theoretical choices were based on the positive and expanded concept of health, moving away from the usual training that prioritizes knowledge based on the concept of disease The concept of culture as a convergence of both the anthropological-cultural and practical-usual senses and the theoretical framework of medical rationalities in health were the theories adopted to bring students closer to health knowledge and practices from different cultural contexts. The theoretical contribution of the contemplative pedagogies and the theoretical-practical reference of somatic education privileged the ways of knowing each other and the other, incorporating the physical, affective, cognitive, and interpersonal aspects to the training Interprofessional training and integration with the community guided the methodological choices: The work methodologies combined the theoretical presentations with invited speakers, the contemplative and movement experiential dynamics, conversation roundtables, and, per the students' suggestion, community snack break

(continued)

Table 28.2 (continued)

Questions	Take-home messages
What kind of forms of assessment are applied, results achieved, and challenges faced?	There were two assessment methods: a formative assessment and a final assessment, the latter containing a self-assessment by the students. The instruments of formative evaluation were conversation roundtables, feedback from monitoring, and supervision of the seminars held. The final evaluation was composed of a conversation roundtable; an expressive plastic activity; and an online assessment form with open questions. The answers of this form were analyzed through this paper. The results show that the methodologies used can produce significant learning and open space for new integrative pedagogical approaches. The main challenges presented in the evaluations were the physical and mental exhaustion of the students caused by the excessive demands in the curriculum, the prejudice concerning non-academic knowledge, and the resistance linked to the processes of corporal experimentation
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The teaching and learning plan was based both on the acquisition of cultural and relational skills and the comprehensive development of students. Cultural skills were stimulated by contact with various health rationalities, which provided access to the meanings of life and health in each cultural tradition that was presented and enhanced by the integration between practice, theory, and conversation roundtables. The relational skills were benefited by the opportunities for coexistence: The heterogeneous profile of the students, the coexistence in the community snack breaks, the speakers' work experiences, and the prioritization of group approaches, aimed at training students for collaborative practices. The support for the comprehensive development of students is needed, from our point of view, for the acquisition of cultural, physical, affective, cognitive, and people skills. This support was given by the experiences of knowing themselves and the other, provided by contemplative pedagogy and somatic education methods
What could others learn with your experience? What is localized and what is "generalizable"?	The success of the analyzed experience depended on local variables: The university's pedagogical project, valuing interprofessional education and integration with the community; the diversity of professionals who practice traditional and complementary types of medicine in this territory; and the repertoire of the teachers themselves, with academic and non-academic knowledge. Therefore, what may be "generalizable" in the model of the course is the approach of teachers to the local reality and the articulation of partnerships with the community to bring popular knowledge and practices into the academic environment; additionally, the somatic approaches should be noted, as they aim at the integral development of students Health promotion implies overcoming epistemological barriers that keep health education restricted to conventional curative medicine, hegemonic in most countries. In our view, this is a "generalizable" challenge, which requires local responses. We hope that this experience report can inspire new initiatives

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Chapter 29
Teaching Suicide Prevention: Experiences from a Social-Ecological Approach

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Contents

This chapter discusses the teaching opportunities and strategies embedded in the planning and implementation of health promotion projects targeting suicide prevention in the university context. The perspective adopted is that of an informal advisory group nestled in the psychology school clinic at the University of Brasília (UnB) in Brazil. Our group operates on two fronts. In an advisory capacity, we help schools within the university conduct a comprehensive collaborative assessment to identify and map out local determinants of suicide risk and protection in tandem

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with assisting executive academic coordinators in any matters pertaining to suicide prevention. In a formative capacity, we conduct mental health awareness and health promotion skill-building activities with the schools and provide in-service training to junior psychologists[1] in suicide prevention and health promotion.

Our group is called *Grupo Entrelinhas*. In Portuguese, *entrelinhas* means between the lines, a nudge to the notion that suicides communicate, albeit tragically, that which is not being ordinarily heard or spoken. We believe that suicides should be seen not only as signs of individual and familial suffering but also, and importantly, as byproducts of overarching socioeconomic and cultural structures, with historically developed mechanisms of power and oppression that materialize in unhealthy environments and relationships. To advance general quality-of-life strategies, social equity, and health education is thus an integral part of suicide prevention.

Historical Background

Suicide is the second leading cause of death among youth aged 15 to 29 years old worldwide (World Health Organization [WHO], 2019). In Brazil, 13,520 suicides were registered in 2019 alone, of which more than 28% (3862) occurred in the 15- to 29-age group, an increase of over 39% compared to the number of suicides in this age group in 2009 (SIM/DATASUS, 2009–2019). Some estimates indicate that every suicide may affect upward of 100 people, and suicide-exposed individuals report suicide ideation at almost double the rate of unexposed individuals (Cerel et al., 2019).

Grupo Entrelinhas was launched in early 2018 after several suicides were identified in the student body at the university over the preceding 2 years. Although in UnB a public unifying dataset of student suicide behavior (here understood as attempts and deaths) is unavailable, according to newspapers at least five departments within the university experienced student suicides (Antunes, 2018). In the same period, an apparent growth tendency in student suicide behavior throughout the country also made headlines (Cambricoli & Toledo, 2017).

A nationwide survey reported deteriorated mental health among college students, with over 80% facing varying degrees of emotional problems, 60% reporting anxiety, and 8.5% reporting suicide thoughts, a percentage of suicide ideation that more than doubled in relation to the previous survey, 4 years earlier (FONAPRACE, 2019). This growth tendency is not specific to Brazil; increased demand for student counseling services has been identified internationally (AUCCCD, 2019).

This data highlights the widespread prevalence of suicide behaviors and ideations among the university student body in Brazil and the pressing need for a coordinated and effective effort in mental health promotion in higher education.

[1] In Brazil, those are typically holders of a degree in a five-year undergraduate course in psychology

Challenges Faced In light of several suicides in the student body, hundreds of students potentially affected, and the impossibility and inadequacy of providing mental health care in the traditional individual session model, the challenges our group faced were trifold:

- Empowering university communities to take ownership and agency over the factors influencing their mental health,
- Delivering widespread first-tier mental health care focused on promoting and solidifying suicide protective factors, and
- Immediately supporting multiple individuals in grieving, attempting to prevent suicide contagion, and identifying those at an increased risk of worsening mental health status, while avoiding burnout of understaffed mental health professionals.

Crises as a Gateway to Approach Mental Health Promotion

Grupo Entrelinhas' effort focuses on signaling the need to rethink response strategy to suicides in university communities. The group's overarching approach is to enhance the general level of wellness in the university's communities by encouraging health consciousness in all daily activities. Instead of reacting with large-scale mobilizations following a suicide crisis, our group advocates identifying and changing general underlying processes that might be contributing to worsened mental health status. Furthermore, our interventions aim to acknowledge and strengthen skills already existing within the university's communities, thus empowering all to take ownership and agency over the betterment of their mental health.

In this sense, our work philosophy is fully aligned with the Ottawa Charter for Health Promotion (WHO, 1986) in the action guidelines of strengthening community action, developing skills, creating supportive environments, and reorienting health services.

Workflow Our services are requested by academic coordinators within the university who identify a mental health demand in their student, faculty, or technical body, usually following either a suicide or suicide attempt.

Our first approach is supporting academic coordinators in handling and communicating about initial aspects of the crisis. We then offer group suicide postvention interventions to bereaved school communities. Our postvention protocol involves active search of affected peers.

In terms of reach, at least 143 people participated in a total of 8 targeted postvention actions from April 2018 to November 2020. These interventions were met with very positive reactions and serve as a gateway in inviting schools' decision makers to engage in health promotion and suicide prevention planning.

Once an academic coordinator signals interest in creating a suicide prevention plan for their school, we begin by carrying out a comprehensive and participative

mapping of the school's situation regarding any factors that might play a role in the current mental health status of the group. We call this process a Situational Diagnostic. We are oriented by an overarching social-ecological framework to health promotion (Bartholomew et al., 2006) that recognizes an interplay of individual, interpersonal, organizational, environmental, societal, administrative, and political characteristics influencing mental health. Relationships between these levels are complex and reciprocal. The Diagnostic aims to identify, in the target community, these various influences, as well as specific demands for training in psychological competencies and skill sets.

We begin by conducting interviews with the academic coordinators, followed by separate focus groups with professors, technical staff, and student representatives. If additional interest groups are identified, such as black students or women empowerment groups, their representatives are invited to interviews. These initial talks aim to identify the communities' challenges, barriers, needs, and good practices regarding mental health. It is an effort in giving voice to every stakeholder.

We then review the school's official website and material from open social media accounts linked to the course. The website reviews intend to identify ease of access to information on health services available to students and on important academic rules, occurrence of language insensitive to minority groups, and confusing or otherwise unsuitable communication styles. The social media accounts are browsed to identify both the general mood of the school's communities as well as recurring mental health themes. In addition to this document analysis, we also visit the school buildings.

Collected data are organized and presented as a mind map illustrating every issue identified by the communities' stakeholders, document analysis, and environmental visit. Data are clustered by type of issue and interest group, and related, when possible, to suicide protective factors and risk factors. A mind map is an interesting tool as it allows the portrayal of complex relationships. In the same mind map, we include a proposal of actions, both punctual and continuous, revisional and propositional, aimed at promoting that communities' mental health by strengthening and encouraging new protective factors and minimizing the risk factors to suicide and barriers to mental health. We signal which of these actions can be carried out by our group and indicate which services, people, or places can be sought out for the others.

This final assessment format was developed over a couple of years and began to be implemented in 2019 with four pilot schools within the university. The huge scope of this work means that only very few schools can be assisted at the same time. However, it has the potential benefit of empowering communities to gain ownership over their processes and effectively target areas for change.

Figure 29.1 describes Grupo Entrelinhas' workflow in five stages: First encounters, Work proposal, Situational Diagnostic, Diagnostic feedback presentation, and Implementation. Each stage is subdivided into actions. The relationships of each action to the health promotion core competencies applicable are displayed.

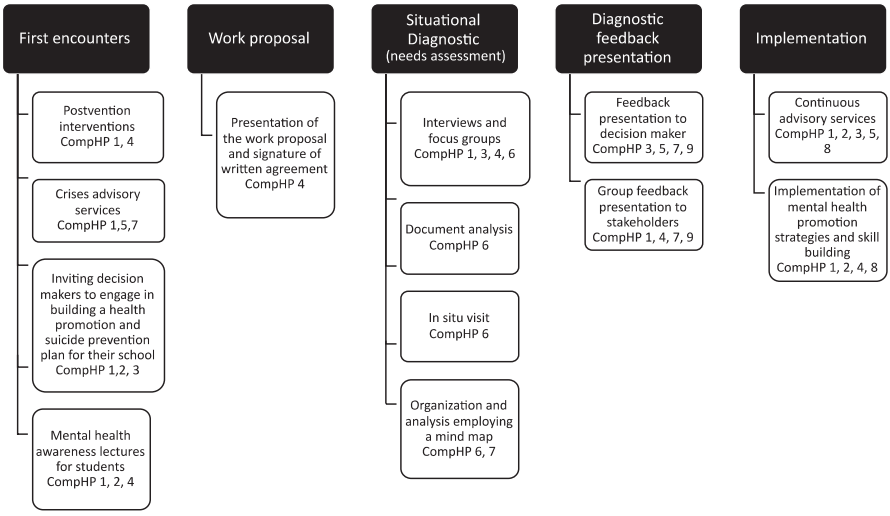

Fig. 29.1 Description of Grupo Entrelinhas' workflow

Teaching Opportunities, Practices, and Strategies

Our work yielded two categories of teaching opportunities. The first concerns the in-service training of four junior psychologists who joined us from October 2019 to October 2020. The objective was preparing them, through active learning methodologies, to plan and implement health promotion interventions linked to suicide prevention. The second group of teaching opportunities was embedded in *Grupo Entrelinhas*' interventions with school communities.

Teaching Junior Psychology Interns

All four interns were psychologists but differed in their clinical backgrounds: cognitive behavioral psychotherapy, psychodrama, psychoanalysis, and body-oriented psychotherapy. They were two women and two men, ranging in age from 27 to 58, all with little clinical experience.

Interns assumed diverse roles throughout the year. They were required to participate in a weekly general meeting. This meeting alternated between literature review discussions, skill-building sessions (for clinical interventions and self-care), group-building exercises, simulations, mock project presentations, and general coordination sessions. Interns acted as primary therapists in up to three cases each,

participated in a weekly group case supervision session and as observers in some awareness lectures and data collection sessions. Part of the group additionally participated as cotherapists in delivering skill-building sessions.

Active learning methodologies were prioritized in training, building from junior psychologists' previous declarative and procedural knowledge of case management for at-risk patients, assessed by an interview and case study during the hiring process. We will now turn to the main categories of activity.

Simulation: Suicide Awareness Talk

Interns had to prepare and deliver a suicide awareness talk and support material geared toward university professors. They delivered this talk to the senior psychologists in *Grupo Entrelinhas*, who role-played as faculty varying in degrees of acceptance toward the activity. Interns had to manage the technical aspects of the talk (risk and protective factors of suicide), their general standing as speakers, and their delivery to an audience with mixed acceptance toward mental health issues. The main compHP competencies targeted were communication, advocate for health, and implementation, the latter related to developing appropriate resources and materials (Dempsey et al., 2011).

Mock Project: Mental Health Question Box

Interns were asked to devise a way to collect and answer mental health-related questions posed by the community. They were asked to think about two options for collecting the questions: online and in situ. The specific competency domain targeted was Planning (Dempsey et al., 2011). Interns worked as one group and presented both options to senior psychologists as if they were presenting to schools.

For the in situ scenario, they opted for a physical box to be left at schools and later collected. Concerns were balancing visibility and privacy of the boxes, rendering them tamper-proof, organizing a timescale for their retrieval, discouraging prank questions, thinking of a proper forum for answering the questions, and managing crisis scenarios.

For the online situation, they opted for a question box in Instagram stories, with a 24-hour viewing period. Additional specific concerns of this modality were related to the organization of response by the interns while using a single Instagram account, especially if it attracted a lot of traffic.

This activity was carried out in early 2020. A subsequent trial run was not possible due to COVID-19 pandemic onset.

Suicide Prevention Environmental Intervention

In Brazil, suicide awareness campaigns are commonly held in September. In 2019, *Grupo Entrelinhas* decided to modify the psychology school clinic's waiting room with an intervention consisting of a string web high over the chairs, from which colored cards hung. Cards carried poems, music lyrics, and quotes linked to hope, resilience, and self-acceptance. At the end of the month, the school clinic's regulars were invited to take a card and either keep it or gift it to someone else. Junior psychologists participated in choosing the sayings for the cards and setting up the physical intervention. Health promotion competency domains involved were communication and implementation, especially regarding the necessary care in handling cultural aspects of interventions in spaces occupied by multiple people.

Skill Building

Most skill-building sessions were integrated with clinical supervision sessions and involved role-playing the management of crises encountered with patients during the previous week. Detailed feedback, reinforcement, and role models were provided regarding the delivery of specific clinical strategies such as anger and impulsivity control, assertive communication, grounding techniques, and relaxation and breathing exercises. Interns were invited to reflect on their emotional process during the handling of crises and when receiving feedback. This attention to emotion is crucial, since self-care is a vital skill for psychologists (Ziede & Norcross, 2020). Specific tool training sessions were also held, with guided practice on using the mind map program and filling out the school clinic's extensive paperwork. This approach to enhancing self-efficacy is grounded on Social Cognitive Theory as applied to the development of skills, which includes the strategies of modeling, guided practice, enactment, verbal persuasion, physiological and affective change, and facilitation (Bartholomew et al., 2006). Importantly, the strategies and techniques were not imparted upon the interns, but rather elicited through Socratic questioning (Paul & Elder, 2007). This process builds on interns' previous knowledge and asks of them an engaged stance.

Group-Building Activities

VIA Survey

The whole group (four interns and five psychologists) individually filled out the 120-item VIA Inventory of Strengths (VIA 120, Brazilian Portuguese version). The VIA Survey is an openly available tool from positive psychology that aims to identify a person's character strength profile. It identifies 24 strengths grouped in 6 virtues (Peterson & Seligman, 2004).

Participants sent the results regarding their five greater strengths and three lesser strengths to the group coordinator, who plotted them on a grid, allowing the identification of the group's general strengths and shortcomings, and giving insight into the potential interplay of profiles and sources of conflict.

The theoretical definition of each strength was shared, as well as what could be expected from their overuse and underuse. The participants then discussed how profiles played against each other and the groups', both in facilitating and hindering communication, and who might better handle which tasks. At the end of the activity, with the participant's permission, the profiles were identified. This was done so that the newly gained awareness could be directly applied to real situations.

Specific compHP competencies (Dempsey et al., 2011) were enabling change (specifically regarding the enhancement of personal skills) and leadership. Interns felt the exercise was relevant to their self-knowledge.

NASA Exercise: Survival on the Moon Scenario

From the group coordinator's perspective, a major turning point for the group's cohesiveness was the NASA exercise "survival on the moon scenario" (NASA, 2006). Participants are asked to imagine they are members of a space crew that experienced a malfunction and now have only 15 objects that survived a crash landing. They have to travel together on the moon's surface to reach a mother ship with only these objects, or all die. The exercise involves ranking the surviving objects in order of importance, first alone, then reaching a group consensus, and then comparing these rankings to NASA specialist rankings. Processes involved in negotiation of the group response are then discussed, allowing participants to have direct feedback on how they act in group settings and the consequences. This exercise targets both communication and leadership competencies (Dempsey et al., 2011).

It is noteworthy that the participants themselves apparently saw less of an effect of this exercise in the subsequent group dynamics than what the senior psychologists perceived.

This exercise can be understood as an adaptation of the interactive method commonly referred to as "think-pair-share" collaborative learning strategy. This strategy promotes individual accountability and group processing, uniting intellectual and interactional aspects of learning (Sharma & Saarsar, 2018).

Feedback Assessment from the Interns

At the end of their contract, interns answered a 12-question survey with open-ended and closed questions. They were asked to rate on a 5-point Likert scale their agreement regarding affirmations about 15 characteristics of their behavior and performance during activities and eight items about the contribution of the internship to

their careers and skills. They also rated the internship from 1 to 10. In addition, they were asked to write about the biggest challenge they successfully faced, which issues remained challenging in the management of suicidal patients and suicide prevention, what they thought about the activities of the situational diagnostics, and which activities from the internship they least and most liked, and why. They were also asked if they had any suggestions about the activities, whether they would recommend the internship to other people, and what they thought about the size of the group.

Interns indicated that the internship contributed to their professional qualification and clinical practice and that they felt safer in managing cases with suicidal risk. They also appreciated the novelty of the learning opportunity provided by their participation in the situational diagnostic stages.

Teaching Opportunities while Working with University Communities

Mental Health Awareness Lectures for Students

The breadth of health services available to university students is frequently not known by them. *Grupo Entrelinhas* has a standard "stress and self-care" lecture aimed at first-year students. It is divided into four parts: (1) university's student support network and services, (2) reflection on what makes one's life worthwhile and the role the university plays in this process, (3) quality of life and stress physiology, and (4) stress management exercises. Before the exercises, students take a measure of their respiratory rate and are instructed about anxious breathing patterns. Then they practice basic exercises that teach relaxation: breathing, face relaxation, and imagery visualization. Lastly, students are presented with an assortment of mental health apps and online resources, and general guidelines about types of issues that benefit from talking to a therapist. Students are encouraged to follow the psychology school clinic's Instagram, which advertises free mental health events, services, and materials.

This lecture has been delivered to over 300 students from at least six schools within the university. It is aligned with the World Health Organization's understanding that mental health awareness and knowledge of how to access mental health services are important strategies of suicide prevention at the universal level (WHO, 2014). One of the objectives of the lecture is to normalize help-seeking behavior, especially as there is evidence indicating that help-seeking is not necessarily seen as important by people with recent ideations (de Luca et al., 2019) and is hindered by self-reliance, social stigma, and treatment fears (Michelmore & Hindley, 2012). We also act with the understanding that strategies for mental health support may not be well known by the school's faculty and staff.

Skill Building: Public Speaking Workshop

A public speaking workshop was offered in November 2019. Oratory was chosen as an initial theme due to the high impact that communication anxiety has on students. Since oratory training is not traditionally understood as a mental health intervention, we also felt it would be better received by students and offer a safe entry into aspects of self-care.

There is evidence that fear of public speaking is prevalent worldwide, with reports as high as 63.9% in Brazilian university students (Marinho et al., 2017). Public speaking anxiety can negatively impact learning and social interaction (LeFebvre et al., 2019). The oratory workshop aimed to develop a higher sense of self-efficacy in communication skills so that students could better manage their anxiety and deliver required public speeches.

The workshop was structured in five weekly modules: (1) challenges of public speaking and voice characteristics, (2) planning and structuring presentations and the use of PowerPoint, (3) improvisation and speech fluidity, (4) the use of emotions in speech, and (5) debate cycle and final presentation. The overall focus was on enhancing stage presence in speech delivery, and diminishing stage fright.

Sessions were heavily reliant on group work and shared feedback. Contents were developed through fun, hands-on group activities that required participants to interact, try out new skills, make mistakes, loosen up, and integrate body movement, facial expression, and speech. Since the overarching idea was to foster ease in speaking to an audience, most of the exercises' actual content was either pop culture, funny, nonsensical, or otherwise not serious. For example, in a round of debates between two participants, the debate topic was "which creature is the most dangerous?" Debate pairs were: medusa or mermaids, Santa Claus or the Easter Bunny, pirates or ninjas, and zombies or werewolves. The use of this type of content in exercises guarantees a relaxed and explorative atmosphere. Conversely, the final presentation simulated an actual speech students had to deliver that semester. Exercises were recorded, and participants had access to the videos of their performances, with individualized feedback.

The group was composed of nine participants: the main instructor, an assistant, and seven students from different schools in the university. An additional assistant participated in specific modules. Both assistants were interns.

Feedback on the workshop was overwhelmingly positive. The evaluation asked participants to write their thoughts on the explanations and exercises for each module, and any suggestions. They also evaluated the instructor and aspects of the group format of the activities. Respondents indicated they were interested in continuing this activity should advanced modules be offered and they would recommend it to others, some already had. All indicated improvements in outcome such as feeling calmer when speaking in public, not being so afraid of making mistakes, dealing better with insecurities, gaining more control, better posture and movement on stage, dealing better with possible blanks when speaking, modulating voice, dealing

better with agitation and unease, and generally feeling their speaking abilities improved. One month after the end of the activities, one participant informed us the workshop had been instrumental in securing a position in the job market. The onset of the COVID-19 pandemic curtailed the implementation of further group activities.

Community Welcome and Networking Workshop

In 2012, the university banned violent or humiliating student hazing. Student veterans and academic centers have increasingly relied on get togethers, sport and play activities, or socially responsible activities as a substitution. From the initial situational diagnostics, we noticed that schools struggled with students who had difficulty fitting in with the group. Considering that lack of social connectedness is recognized as a risk factor for suicide (Poland & Ferguson, 2021), we decided to offer a workshop tailored to student union members who are frequently in charge of welcoming first-year students. The idea was to instrumentalize these students in using group activities to integrate newcomers while still being fun. Besides experiencing firsthand the suggested activities and resources, students also discussed a rationale for each activity.

Participants were 12 student union members from different schools. Their impression was that the workshop offered them structure, organization, and a theory basis in thinking of humane strategies for greeting newcomers. They also thought it a new and welcome space for exchanges between students' representatives from different schools.

Psychological Advisory Services for Academic Coordinators

Since most schools solicit our services following a student suicide or attempt, our group's first activities are postvention interventions and crisis management, such as advising the academic coordinator on how to handle communication, spontaneous and formal tributes, memorials, and gatherings. Avoiding suicide contagion is a pressing concern. A timely and respectful approach to these situations is paramount.

Following crises, schools are permeable to difficult talks about mental health needs. From the point of view of a school's decision maker, under the theoretical standpoint of the Health Belief Model (Champion & Skinner, 2008), you could say a student suicide is a powerful cue to the action of addressing students' mental health concerns. Additionally, the perceived susceptibility to and perceived severity of the problem are high. The perceived benefits of action are also high and the perceived barriers are momentarily lowered, as there is a general sentiment of avoiding further suicides at all costs. A challenge is related to a possible low self-efficacy of this decision maker, as the worst possible outcome may have already happened.

One of the main characteristics in conducting the Situational Diagnostic is the effort to actually understand how the problem presents locally and to identify the specific determinants before proposing solution strategies. Although the benefits in doing so are self-evident, we must recognize the heightened level of pressure felt by decision makers who need to rapidly respond to mental health incidents in their community, which frequently leads to the implementation of general mitigation strategies that are not tailored to their department needs. This in turn may lead to a low level of community engagement in such strategies and a general feeling of helplessness. Reassuring school's deans, department chairs, and executive academic coordinators of the importance of this assessment prior to the commitment to a specific course of long-term action is a laborious and necessary process that directly touches on issues of leadership and communication, both for the health intervention team and for the decision maker.

Situational Diagnostic

In the second semester of 2019, four schools signed with *Grupo Entrelinhas* to plan and implement a suicide prevention program tailored to their realities. When the COVID-19 pandemic began, the situational diagnostics of two schools had been completed and were in the early stages of the feedback loop. The other two were still in different stages of data collection. Important initial reactions and responses were identified.

During the feedback meetings, we noticed that one of the main benefits of the mind map was prompting individuals to understand poor mental health as a common challenge that all stakeholders were facing together, but that expressed itself differently across groups. It allowed each group to confront their responsibilities in the dynamic and their blind spots in evaluating the problem, and to recognize potential areas for positive contributions.

Throughout the situational diagnostic stages, changes were already taking place. Schools began reconsidering quality-of-life interventions dropped over the years and discussing the possibility of forming mental health working groups or having specific professors who could be mental health references for students. With better communication, management corrected minor maintenance issues that influenced staff's feelings of personal safety. One school organized a faculty meeting to talk about risk and protection factors for suicide. Activities that empower people in gatekeeper roles, such as professors in university settings, to better identify risk and counter misinformation are necessary (Poland & Ferguson, 2021).

Throughout the year, we also noticed a general rise in interest in the group's work. Staff from another sector of the university requested guidance on conducting a similar situational diagnostic on their premises. Professors and students heard about the work and approached us wishing to enhance suicide prevention in their schools. Other universities invited us to deliver lectures in suicide prevention.

The COVID-19 pandemic brought the diagnostic activities to a standstill and suspended all in-person activities indefinitely. In light of the limitations, *Grupo*

Entrelinhas decided to focus more closely on training professionals and offering emotional support for the community. Interns provided fixed hours for telephone and video calls, in the fashion of a helpline. Additionally, an 8-hour online training on suicide prevention was elaborated and offered to recently graduated psychologists. The group also launched a booklet entitled Suicide prevention: initial guidelines for university professors.

Media Coverage

To assess *Grupo Entrelinhas*' reach over time, we searched for all of the group's Google mentions from February 2018 to March 2021. *Grupo Entrelinhas* was mentioned 34 times in digital media posts, pages, and articles, from university pages and local media to national media vehicles, excluding pages directly linked to the group and group member profiles.

Of these mentions, we highlight 18 newspaper articles, 14 of which were the reproduction of the same article by different vehicles, suggesting the importance and scarcity of initiatives in this area.

Challenges and Obstacles Encountered

Grupo Entrelinhas is founded and run exclusively by psychologists who are staff and not faculty at the University of Brasília, incurring in legal and structural limitations on autonomy, funding and engagement of talents, as well as encountering additional bureaucratic hurdles.

Another general issue concerns the difficulty in obtaining and generating good quality data regarding suicides, suicide attempts, and interventions. Data baselines are often missing. There is widespread underreporting (Tøllefsen et al., 2012). This is not specific to our context; rather, it is a common occurrence and may be linked to various cultural, religious, social, and legal reasons, particular to deaths by suicide (Naghavi, 2019). Potentially unreliable and missing data are an obstacle in assessing the effectiveness of suicide prevention programs.

Obtaining outcome and impact data following suicide prevention and especially postvention interventions is particularly difficult, as the subject matter is very mobilizing, and populations involved may be in an extremely vulnerable position. Careful planning of and previous agreement on data collection points might circumvent some of these difficulties.

Challenges Related to the Internship

A major challenge is that the intern position is not paid and, as such, competes with remunerated activities. The unpredictability of the schedule for the community interventions is another difficulty. Postventions are by nature emergencies, and the diagnostic process's steps rely on the communities' availability, making scheduling and transportation planning challenging, especially as interns commonly live far away from the university. Interns' low computer literacy and working knowledge of the English language are also hindering issues.

Challenges Encountered while Working with School Communities

Academic coordinators usually serve a two-year term. Health promotion continuity in the face of frequent change within the schools is a challenge and relies heavily on political will. One possibility of addressing this difficulty is having either a work-group or a specific faculty member acting as a mental health liaison, undeterred by changes in management.

At the feedback meeting, the health team must pay close attention and intervene to dissuade unhealthy developing dynamics, such as invalidation of specific group's perceptions or scapegoating. Four guidelines curb these occurrences: (1) the decision maker who initially requested the assessment should be debriefed separately and thoroughly a few days before the meeting; (2) more than one representative of every group that participated in data collection must be present at the feedback meeting. Should the meeting not take place, all stakeholder representatives get a copy of the report; (3) the health promotion team clearly communicates the procedures and scope of the data collection carried out, including whole groups that may have opted out of participating; (4) group perceptions are presented as such, there is an absolute protection of precisely who said what. A successful feedback meeting is invaluable in promoting an integrated understanding of the multiple factors influencing mental health status in the school and in promoting a joint effort of all stakeholders, different as they are, in tackling the problem together, instead of assigning outside blame. This process is an opportunity to promote the competencies of enabling change and mediating through partnership in communities (Dempsey et al., 2011).

Although there are many challenges, our work so far has been welcomed by the university communities and administration. We hope that the experiences described in this chapter may inspire other initiatives in suicide prevention in university settings.

Table 29.1 brings our reflection on the six triggering questions suggested by the Editors.

Table 29.1 Authors´ reflections on the six triggering questions suggested by the Editors

Questions	Take-Home Messages
What is our vision about HP?	We adopt a social-ecological approach to health promotion, where contributions to any issue arise from the interplay of individual, relational, organizational, environmental, and societal/cultural influences. Our vision is that health promotion will become an integrated transversal topic in every area of knowledge, empowering different professions to contribute to overall health with their specificity. Planning health promotion programs, on the other hand, is a specific skill geared toward the health sciences, whose practitioners should work in close collaboration with decision makers.
What is the institutional and political context of your experience (participants, professions and courses involved, duration, and frequency of activities)?	We work on two fronts: Training junior psychologists and working directly with university students and schools in the delivery of suicide prevention services. On the one hand, we provide junior psychologists with 1 year of in-service training in suicide prevention, as well as planning and implementation of health promotion projects. On the other hand, schools may request a targeted service of suicide postvention and suicide prevention planning, where strategies for mitigating risks and amplifying protective factors are tailored to their reality after a careful diagnostic process. We also work directly with university students in providing group mental health awareness activities, skill-building activities, and network-building activities. Across all activities, *Grupo Entrelinhas* reached members of at least 22 schools: Accounting, Administration, Agribusiness Management, Agronomy, Chemical Engineering, Computer Sciences, Economy, Forest Engineering, International Relations, Languages, Law, Library Sciences, Medical School, Music, Pedagogy, Pharmacy, Physical Education, Physics, Psychology, Social Sciences, Veterinary Medicine.
Which theories and methodologies are used in the teaching-learning process?	Our overarching framework for understanding health promotion is a social-ecological model. Other theories, such as the Health Belief Model and Social Cognitive theory, may inform interpretations regarding specific processes of individual decision making and skill building. For the psychologist's training, we use active collaborative learning methods such as problem-based learning, simulation, role-playing, and mock projects. Skill-building activities, group-building activities, and group supervision of cases are cornerstones. The work with school communities, especially during the Situational Diagnostic, is oriented by a participatory-action research methodology.

(continued)

Table 29.1 (continued)

Questions	Take-Home Messages
What forms of assessment are applied, results achieved, and challenges faced?	For the junior psychologist's training, we measure outputs and perceived outcomes at the end of their internship through a survey with a mix of open and closed questions. All activities are also continuously assessed verbally throughout the year. With school communities, we measure service outputs, specifically the number of people served per activity, number of activities and services provided, media exposure, website hits, and number of downloads of mental health resources. Skill-building activities have a detailed specific survey that touches on perceived outcomes. At the end of every mental health awareness activity and suicide postvention, there is an informal assessment. Expectations and delivery of advisory services are continuously discussed verbally with school's decision makers. Assessing outcomes and impacts is extremely challenging in the context of suicide prevention and postvention due to the delicate nature of the subject matter and data gaps on baseline conditions.
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	With school communities our effort is geared toward enabling lasting change. We seek to promote mental health consciousness, strengthen agency and ownership, develop useful skill sets, promote safe and positive interaction between groups, and encourage collaborative problem solving that fosters understanding of the underlying processes that may generate and maintain negative mental health outcomes. With junior psychologist interns, we hope to instrumentalize them in conducting integrated and participative assessments and interventions tailored to their client's needs and thinking about health promotion and suicide prevention more as a community-based intervention, rather than an individual one. Communication skills, planning skills, group work, and the ability to integrate different viewpoints are essential.
What others could learn with your experience? What is localized and what is "generalizable"?	The planning of specific health promotion programs must be requested and sanctioned by a high-ranking decision maker within the target school, as access to people, places, and resources depends on this. An initial diagnostic of the situation is paramount and must be understood and supported by decision makers. Feedback on the Situational Diagnostic should be given in a group setting, with representatives of all stakeholders present. Continuity is a challenge due to frequent changes in administration. Creating a stable mental health liaison role can perhaps facilitate these adaptations. Group-building activities and self-care are cornerstones for ensuring healthy intervention teams. Training activities should be tailored to culture and individual skill levels. Finally, difficulty in generating outcome and impact data should be expected, especially in light of absent baseline data. Careful planning of agreed-on data collection points may be able to mitigate this problem.

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Chapter 30
Encounters and Narratives the Insertion of Socio-Environmental Health in the Perspective of Health Promotion

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Contents

Interprofessional Education in Undergraduate Health Program: Formative Context of the Experience

The encounters and narratives are the central object of this descriptive-analytical reflection, having the Institute of Health and Society (ISS) of the Baixada Santista Campus (BSC), of the Federal University of São Paulo (Unifesp), as formative context. This pedagogical project is anchored in the Interprofessional Education (IPE) as a curricular method, a training in which students from six different areas (Physical Education, Physiotherapy, Nutrition, Psychology, Social Work, and Occupational Therapy) learn together about teamwork and the "common" health care from the perspective of comprehensive care and improvement of health conditions of people and the community (Batista et al., 2018; Capozzolo, 2017; Capozzolo et al., 2014).

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Several studies on training in the ISS highlight the IPE perspective, defined by Reeves et al. (2013) as "Interprofessional education is the occasion when members of two or more professions learn together interactively for the explicit purpose of improving collaboration and quality of care and well-being of patients/users, families and communities" (p.4).

It is important to highlight the dimension of the "explicit purpose" in the assumption of intentionality in curricular design when organizing common axes and specific axes[1] as formative paths imbricated, articulated, and integrated in an organic way. Thus, it seeks to overcome the most immediate conception that exposing students to common situations in the same places is enough, when in fact it is necessary to provide learning situations that foster common care (Capozzolo et al., 2020).

In this sense, the organization of interprofessional learning situations implies systematic and sustained interaction throughout the course, dialoguing with the histories and paths of the professions, and with the construction of the extended and shared clinic, seeking to structure the development of specific, common, and collaborative competencies (Orchard et al., 2010).

The experience shared here has the Health Work axis as its privileged curricular space, consisting of five modules distributed throughout the undergraduate years, developed from the expanded view of health, dealing with the demands and health-disease-care processes in the territories and communities. Professors from different health professions are part of this axis, such as psychologists, doctors, social service workers, and dentists, seeking to form an educational team that integrates, dialogues, and anchors a common and in-common care (Capozzolo et al., 2013, 2014, 2020).

Encounters and Narrative Production: A Module in the Training Network

In the module Encounters and Narrative Production, under supervision and permanent monitoring, the students are in contact with users of health services in their territories of life. The objective of this meeting is for the students to identify the scope of health policies when they get to know and write life stories; understanding people's and groups' ways of life and health; establishing a favorable environment for creating a bond with the other, for sensitive listening, careful observation of health demands, seeking to understand how those people face health, disease, and care processes, in addition to the construction of writing through the development of narratives (Unifesp, 2016).

[1] The Specific Axes include the Undergraduate Courses (Physical Education, Physiotherapy, Nutrition, Psychology, Social Service, and Occupational Therapy), and the Common Axes are Work in Health, The Human Being in its Biological Dimension, and The Human Being and its Social Insertion.

The international reference for narratives of health is the narrative medicine by Rita Charon from Columbia University, New York, USA, who shows the importance of valuing the human aspect of the health professional, an essential element for health care (Charon, 2001). Silva and Galiian (2020), in a study with *quilombolas* (slavery-descendant communities), discuss the place of narratives to address the health-illness issue from the point of view of the patient/subject, going beyond the biological and apprehending the social and cultural aspects inscribed in the very vision of falling ill.

Throughout the module, the professor intends to mediate the learning that involves technical-scientific knowledge, knowledge of experiences, knowledge of the other, and knowledge constructed in interaction. Investment is made in the refinement and development of sensitive and attentive listening, mobilizing the senses for relationships based on empathy, on the bond, on ethical commitment, on person-centered attention. Students are stimulated to live the experience, allowing themselves to be touched by it, in an environment where everyone can undergo a transformation.

The activity was developed in groups of up to 12 students in each class, to guarantee the accompaniment of up to six narrators. However, depending on the situation, such as the withdrawal of a student or narrator, this number may vary. On average, each semester had about 10 groups with 12 students each, and 60 narrators participated in the module.

During the preparation for the meeting, students were told about the possibilities of using narratives both for teaching and learning and for research. The importance of exercising a broader view of the issue was also discussed, going beyond the strictly biological and hospital-centric approach to diseases (Amado, 1995; Bondía, 2002; Brum, 2006; da Cunha, 1997; Rozemberg & Minayo, 2001).

The students' narratives are full of past, present, and, sometimes, future perspectives. They are stories about work, health, and love, according to memories the narrators brought up during the meetings, and which were listened to attentively, apprehended, and written down by the student. For being a narrative, its organization may not be rigidly chronological like a biography, since it is built by fragments of stories of a life, with a particular meaning for those to whom it is addressed.

A narrative involves the insertion of the literary art in training, in which students listen, understand, think, and systematize a way of telling a life story. It takes creativity and an involvement to understand the narrative contents which are paramount to each narrator and therefore unique for the nonfictional character who is writing the story. Each narrative is told in a different manner, it is not standardized, since it is written to be given to a narrator who, in turn, will read it and approve it, or ask for adjustments if necessary.

The encounters and the production of narratives are carefully planned, since it is not a manual, but parameters that guide and support the action in the field (Henz & Casetto, 2013). During the module, multiple moments of discussion and analysis are conducted with students and professors. Continuously and permanently, they learn to be in a relation with the other in the production of health care.

At the beginning of the activities, the students are explained the objectives of the module, and during the first month, they receive training in the classroom before going to the field and entering the territory of the users, the narrators. Through reading and collective reflection conducted in the classroom, students are prepared to observe and understand the uncertainties that exist in the relationship between professionals and those who demand health care.

Throughout the process, which is monitored by the professor, the students' objective is to develop and enhance relational skills, so that they have an active stance in human contact, as they will enter the homes of the people they will meet every fortnight until the end of the semester. Four lessons in the classroom are usually enough to start the field activity. The first visit to the narrators' territory is when the students get to know them, the moment when the pairs and trios of students who will interact with the narrators are defined.

After forming the pairs and trios of students and defining the fields, when the users are available to receive the students, the encounters and narratives start. In this activity, students are encouraged to observe with a broader view to identify the contradictions and limitations of economic development, the result of social inequalities in housing, transportation, and leisure in people's daily lives. For the experiment on socio-environmental health, students were prepared to observe the conditions of environmental determinants, especially if it involves a territory with contaminated or pollution-saturated areas.

The following week, after each field trip to contact the narrator, students and professors meet to discuss the texts that are part of the module theoretical framework. It is time to tell their experiences in the field, with the narrator. The reading and discussion of texts help students to interpret and reflect on these encounters, as well as on the attention to the demands related to the health-disease-care processes. This step is important because the articulation of theory with personal and group experience occurs.

Field visits are recorded in field diaries which are individual reports containing intensive, thoughtful, and descriptive notes. The content of this material is the description of the student's observation on the environment and parts of life stories told by the narrator on each visit, in addition to what they felt on each encounter, and the remarks they can make on a theoretical basis, citing and linking with the texts read on the module and others related to this specific axis. All field trips result in field diaries, and the last field diary is a kind of report containing a general reflection on everything that happened in the module.

The field diary is the assessment tool with the largest record of learning, since it is done individually at each visit, being useful for the professor to monitor the student during the process. There is no right and wrong in the students' notes; thus, they are not afraid to give a wrong answer. In this diary, students express what they have felt, what they have seen from the relationship with the narrator and the field partner, in addition to their perspectives and fears, positioning themselves as "unique subjects" in the learning process (Vieira, 2001).

These diaries contribute for the narrative preparation, as they contain all the material gathered by the student, usually more detailed than the narrative that is

given to the narrator, as they are the result of processes that the student goes through and develops during the module, about their personal learning before knowing the territory and the narrator's life story, while the narrative is the return of this person's life story, being the "Ulysses of their own Odyssey" (Brum, 2006).

In biweekly meetings, life stories are told to the students, and in the classroom meetings, they will express their surprises, their matches and mismatches, the narrator's characteristics, and preferences. At the end of the one-semester module, feedback is constructed with their narrators.

In this module, one of the *nodes* of the formative network materialized in the ISS/BSC, in 2017, a professor and graduate students linked to Center for Studies, Research and Extension in Socio-environmental Health (Nepssa) of the Unifesp BSC, experimentally introduced the theme of socio-environmental health in the narrative encounters. This experimentation sought to contribute, above all, to the perception of socio-environmental constraints and determinants in the content of health training.

In this experimentation, students of the six ISS courses were in contact with men and women affected by exposure or chronic intoxication by harmful chemicals present in their territories of work or housing, producing narratives in socio-environmental health.

Narratives of Socio-Environmental Health

The theme of socio-environmental health in the narrative module had the human exposure to harmful chemicals and chemical compounds as its starting point. Based on socio-environmental health, which studies social impacts arising from environmental conditions that are determinants of health-disease processes, the objective of the experience was to insert the issue of chemical safety in health training. Guided by the conceptual model of social determinants and conditioning factors of health and person-centered care from the perspective of care integrality, the socio-environmental health stimulates interprofessional action to promote health in the territories that constitute a sacrifice area, where the processes of environmental injustice unfold.

The socio-environmental conditions in the territories that function as determinants in the health and disease process are components to be observed and considered in the encounters and in the development of narratives. This knowledge should become part of the development of the instrumentality of students, future professionals. Thus, they are challenged to observe with a complex and broader view to all the possibilities of illness that may have environmental causes, including those caused by pollution and environmental contamination.

This exercise is important to the extent that the processes involving health-environment-disease have not been valued in the training, and thus, it demands more visibility in the study and learning phases. Although it is possible to identify the relations between the process of illness and social inequality, life in subnormal

housing, the lack of basic sanitation, poor diet, and hard work, which are constituents of the complex social determination of health, it seems there are no other environmental factors that originated or aggravate them (Acselrad, 2004; Bullard, 2004; Castelo Branco, 2016; Duchiade, 1992; Porto, 2004); thus, it is necessary to go beyond the layers of appearance that make up the social phenomenon.

The objective of working with narratives in this context is to prepare future professionals to understand, diagnose, and act in the local, regional, and national reality, since the issue of harmful chemical substances and chemical compounds spread in the environment is a global problem whose solution requires complex thinking (Morin, 2000, 2003), and actions have to be strategically developed in an interdisciplinary context, with joint action from different professional areas.

A total of five encounters were conducted for the development of socio-environmental health narratives, with students from the six courses on campus, from 2017 to 2019.

The participating narrators lived in neighborhoods on the outskirts of the city, in substandard housing, built on stilts, with poor sanitation, lack of recreational spaces, with intense pollution, and human exposure to chemical emissions from industrial port activities, in addition to other adverse situations that characterize these territorial spaces as environmental sacrifice zones.

The field activities required an active search for narrators. First, community leaders were contacted and the module was explained as for the health, economic, and social issues perceived by them, and the fire that occurred in 2015 in the port area of the city of Santos (SP)[2] and the contained aquatic disposal (CAD) being implemented in the estuary in the city of Cubatão, both in the state of São Paulo, Brazil. The leaders indicated the people who supposedly had been directly or indirectly most harmed by the environmental issues mentioned and were especially important for the viability and safety of academic activities on site. In addition to knowing the territory and its residents, the community leaders gave all the necessary support for the development of the activities on site, from the visit to know the place, the articulation with the potential narrators, and even the logistical planning for the meetings (at the narrators' homes and when not possible, in a nearby public facility).

In all semesters, the activities counted on the partnership of people who had contact with the potential narrators and became part of a collaborative network of health training.

The activities of the first semester of 2017 took place in the community of Jardim São Manoel neighborhood, Santos (SP), where 11 students developed the narratives in pairs and trios with five female narrators living in the community. The activities in the second semester of 2017 took place in the community of the Alemoa neighborhood, Santos (SP), where 10 students developed the narratives in pairs with five female narrators living in the community. The pedagogical activities in 2017 took place in vulnerable communities that suffered from the 9 days of the 2015 fire.

[2] SP - São Paulo state.

In the second semester of 2018, the activities took place in the community of Vila dos Pescadores, Cubatão (SP), with a group with 11 students. In this period, trios were formed, and they had contact with five narrators, three of them were fishermen. This community, in addition to facing the fire at that time, resisted the implementation of a CAD opened at the bottom of the estuary that received five million tons of sediment contaminated with toxic chemicals and chemical compounds at levels above that permitted by legislation, in an area used by fishermen for their fishing activity.

The activities of the groups of the first and second semesters of 2019 were conducted with another kind of narrators, workers who were exposed and chronically intoxicated by bio persistent and bioaccumulative organochlorine chemical compounds in the workplace environment in a factory in the city of Cubatão (SP). However, there was no possibility of taking the students to the territory of the factory which is deactivated due to the environmental contamination and intoxication it caused to the workers.

In the second semester of 2019, exceptionally, 14 students worked in pairs and trios with six narrators. In addition to the chronically intoxicated factory workers, a couple, whose husband was in a state of frail health and suspected of intoxication, also participated. They were the owners of a small farm in a place where the same company had once deposited toxic tailings in the surrounding area and was being decontaminated.

Thus, in 2019, the encounters did not take place in the community, in a territory where the narrators live. They were residents of different cities, and their common territory was the work environment of a factory of organochlorine solvents in the municipality of Cubatão (SP).

Before the first meeting of pairs and trios with their narrators to start the narrative encounters, the theme of socio-environmental health was introduced in an extra class of the module, and proposals and insertions of the issue also happened throughout the course. The documentary entitled *Tonéis de Fogo,*[3] which tells about the fire that occurred in 2015 in the industrial port area of Alemoa in Santos (SP), was presented to the two classes of the first and second semesters of 2017, in order to guide students about the possible health repercussions on health arisen from this type of environmental occurrence.

The class of 2018 worked with residents of the Vila dos Pescadores in Cubatão (SP); thus, in addition to watching the documentary *Tonéis de Fogo*, they watched a presentation on the issue of CAD that was being deployed in fishing locations and affected the fishermen of the community. The activity aimed to expand the students' previous knowledge about the territory of their narrators.

In 2019, the class of socio-environmental health also watched the presentation of other more recent environmental accidents in the region. The case background was also presented, and students were asked to reflect about it, linking the contents of

[3] The trailer of the documentary film entitled *Tonéis de Fogo* can be checked at: https://youtu.be/HY2b4bSZtC0. Accessed in April 2021.

socio-environmental health with the case that was transversal between the narrators, so that they could expand their listening and approach the background they would learn from the narrators' point of view (perception and experience).

The experiences included conversations on the same day that the students' narratives were given to their narrators, considering that the themes of the narratives were interconnected, whether because of the large fire or because of the exposure and intoxication case in the work environment. In order to broaden the possibilities of these moments, a previous articulation with legal professionals was conducted, inserting them to participate in the module in this specific activity when all the participants were present. Thus, people from the community, narrators, students, researchers, professors, and lawyers collectively discussed the cases that were the starting points for the development of the narratives.

In all classes, a picture of the articulation of the various sectors, such as Public Ministries, universities and their study centers, nongovernmental organizations, civil society, public and private, and national and international agencies and institutions, was presented, based on the statement by Silva et al. (2014) that says: "As there is mobilization of other fields of knowledge and professional practice in the practical intersectoral sense, the ability to confront the socio-environmental determinants in favor of health promotion is expanded" (p. 4369). Students are shown the importance of this participation for health protection from the perspective of promotion, prevention, and precaution (essential environmental concept for the protection of human health).

Health Promotion and Socio-Environmental Issue: Between Learnings

Health promotion results in a range of interconnected and therefore complex plans and actions that go through various spaces and sectors of society, governmental spheres, public and social policies, different stakeholders, and institutions, to improve people's and communities' health levels and quality of life. For that, it is necessary to aggregate social, environmental, economic, and cultural aspects, which contemplate such amplitude. In this perspective, social determinants are like bridges to the paradigmatic horizons of a fairer, more democratic, inclusive, solidary, potentially emancipating, humanized, environmentally balanced, sustainable, and, indeed, healthy society. The insertion of dialogical, critical pedagogical processes, listing health-promoting principles in education, is one of the means for the university to socially contribute to this construction in cooperation networks (Brasil, 2002, 2015; Malta et al., 2018).

Health training based on IPE and insertion of the socio-environmental health theme creates spaces for discussion and learning in the classroom with students from different courses, developing as a critical pedagogical process. In these

narrative encounters, professors, students, narrators, and researchers are strengthened by the relationship that is established in favor of individual and collective health.

The cross-cutting introduction of socio-environmental health, which involves components of environmental health and the social determinants of health in training, has been a factor of change in the way of thinking and attitudes of students and narrators, who perceive themselves as subjects of rights, and this is an expected attitude when reviewing their story told by others, which, in turn, also review their positions, discovering social contradictions that result in inequities in the territories and therefore in people's lives.

The moment of collective encounters, involving narrators, professors, researchers, and residents, demonstrates at each meeting the human potential for psychological, material, and spiritual growth, as well as instigating deeper collective reflection with the elements apprehended in this powerful cauldron from which ideas boil.

Throughout the process, it was possible to promote the articulation of knowledge already brought by the students, from personal, professional life or other formations, to the knowledge that was being constructed in each encounter with the narrator, in the dialogue and exchange of ideas, in each conversation with their pair or trio about the story they heard, about the person they met, in each meeting in class and in discussion with the group that, although having different narrators, shared the same theme that linked all of them in a central way.

The wealth of learning is seen in practice, with the contact with the other and the fact it depends on various inter-relational, intersubjective factors, when there is dialogic interaction. The creation of a bond is one of the challenges for the students because it involves relational factors and subjectivities. This is an important point to be worked out with the student, having in mind that when it comes to human relationships, although a plan is made, sometimes things do not happen as planned.

Thus, even having the narratives on the socio-environmental health issue as a starting point, other issues observed and experienced by the narrators are being relived, brought to memory, and shared with the students. Therefore, the learning is expanded, in which an environmental issue becomes social and environmental injustice when in the territory of people whose social fragility is evident.

Writing the narrative, which must be given to the person who accompanied the student during the semester, the narrator, can be a significant challenge for some students. The contact with the reality experienced by the narrators of the community and their life stories instigates the students, as verified in the field diaries, in the final report of the activity and in the class meetings, to the development of critical analysis on the presence or insufficiency of prevention, protection, and care, including palliative health care.

As for the narratives developed in the communities, more specifically about the fire and the chronic pollution in the Alemoa region, the students described the observation of the narrator's feeling of powerlessness, or the fact that they blame themselves for being exposed to adverse situations, even though they did not know about the risks and had no alternatives such as financial conditions to move to more

protected places, or emergency plans by the government or local companies. However, the students also registered how narrators' opinions changed after the meetings in which they relived and reflect on the facts, showing that these narrative encounters and the fact they were heard by members of the university are important elements in this process.

In the field of health promotion, the experience of pedagogical intervention expresses the place of interprofessional training, the learning of collaborative practices with emphasis on sensitive listening and sharing of knowledge, in the relationship and in the creation of a confident and safe environment. From this perspective, health promotion is combined with permanent care processes and collaboratively constructed, strengthening social control, and fostering the emancipatory autonomy of the subjects involved in the process.

The spaces, which include sources of pollution, polluted and contaminated territories, and exposed populations, provide important learning to understand health in its broad conception and opportunities to discuss possible strategies for professional and population action in the territories where the dynamics of health-disease-care processes occur. The interprofessional proposal and the inclusion of socio-environmental health productively articulated the triad health, environment, and society, showing potentiality for health promotion practices.

The insertion of socio-environmental health in the context of health narratives proved to be powerful for the student approach to the knowledge of the social determinants and conditioning factors of health, for a comprehensive care that considers the promotion with attention to the principles of prevention and precaution, the latter as a key element to avoid that scientific uncertainties are justification for the implementation of systems that bring risks to the environment and therefore to fauna, flora, health, and human life.

Pollution is expressed in multiple ways and with various local, regional, and global scopes, affecting, in a more incisive way, the socially vulnerable populations always pressured by economic development at the expense of human development. To bring the student closer to the communities to understand the health-environment-disease-care processes in the territories and how the people in them perceive themselves before a certain reality constitutes an ethical-academic-political trigger in the field of professional and interprofessional learning, recognizing the potential of concrete and transforming actions from the perspective of health promotion.

Health education that invests in professionals prepared for teamwork, with active listening, interprofessional, and intersectoral coordination skills in the search for strategies to equate and address socio-environmental issues in historically polluted areas, as well as in potential processes of daily chemical exposure to the most varied sources, such as unhealthy environments, products and foods of daily use, and consumption with undesirable levels of hazardous chemical agents or residues, makes explicit intentions to understand the social determinants of health, recognizing the environment as a constituent of the determinants in health-disease processes. It also favors the strengthening of the organization of users of public services through participation in the meeting with the group of narrators in which the common demands

emerge as a form of interaction and collective reflection, as an encounter of opportunities for mutual knowledge between people and insights.

Narrative encounters are inserted in the context of methodologies that facilitate the cultural matches/mismatches of ideas, being part of the relationship between students and narrators that demands active, participatory, critical, and inventive attitudes from the subjects involved, such as students, professors, and the community. The insertion of the socio-environmental health theme, studying the illness caused by environmental factors with attention on the individual (understood in their intersubjective and socially conditioned determinations), has unveiled as "localized" the polluted territories (themes that give rise to narratives on socio-environmental health) and the interactions that are produced and producers of narratives, and as "generalizable" the very theme of socio-environmental health (global pollution present in industrially developed societies and the harmful effects of human exposure to substances, products and chemical compounds present in the territories in various ways) and the production of narratives as a methodological strategy that enhances the meaningful and inventive learning in the training of ethically involved, socially referenced, scientifically rigorous health professionals. A health training is constructed between the "localized" and the "generalizable," which is also epistemologically and methodologically anchored in health promotion as a formative and interventional field.

Table 30.1 brings our reflection on the six triggering questions suggested by the Editors.

Table 30.1 Authors´ reflections on the six triggering questions suggested by the Editors

Questions	Take-Home Messages
What is our vision about HP?	Health promotion is an ethical-political-cultural process in continuous movement with the objective of acting in the social determinants of health aiming at improving the quality of life, contributing to the creation of collective and individual conditions to produce life with autonomy and empowerment. Health promotion calls the professionals to the territories, in the expanded perspective of health and in dialogue with the existing forces, the ways of coping with everyday life, and the construction of life strategies.
What is the institutional and political context of your experience (participants, professions, and courses involved, duration and frequency of activities)?	The ISS pedagogical project, based on the IPE in health, is anchored in the expanded health process, covering attention, health care practices, and health education, configuring learning spaces inserted in the daily lives of communities, health services, and their articulations of the environmental issues, supporting the three academic functions, namely teaching, research, and extension

(continued)

Table 30.1 (continued)

Questions	Take-Home Messages
Which theories and methodologies are used in the teaching-learning process?	We start from the powers of interdisciplinarity and IPE to address the complex health-environment-society. In this context, to develop this approach, the complexity theory (Edgar Morin) was chosen as a theoretical approach in the development of activities under the module encounters and production of narratives, part of the common curricular Axis of work in health. In this module, students of nutrition, physical education, social work, psychology, occupational therapy, and physiotherapy, in pairs or trios, met biweekly with people whose working or living territory are chronically contaminated and/or polluted areas. In these meetings, based on the active methodologies, with the support of bibliographic references worked in the classroom, it sought a participant posture of the students throughout the process, as well as their understanding for the historicity and the moment of the narrator, their survival strategies, and autonomy of people and communities throughout a semester.
What forms of assessment are applied, results achieved, and challenges faced?	The elaboration of field diaries that are prepared by the students at the end of each meeting with the narrators; the participation of the students in the readings, presentations, and discussion of the theoretical framework; the presence and participation in the meetings with the narrators; the feedback of the results to the narrator; the text with the final narrative; and the student's report of the experience are continuously evaluated and conform the student's final evaluation. The adequate time for the creation of a bond between students and narrators has been one of the biggest challenges. Building a broad view of health that adds, in a complex way, the socio-environmental issue, with the participation of professional knowledge not always present in health training is also a challenge. The field diaries and final reports of students have allowed improving the introduction of the theme socio-environmental health in health education.
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	A health education that invests in professionals prepared for teamwork, with active listening, interprofessional, and intersectoral articulation skills in the search for strategies to equate and address socio-environmental issues in historically polluted areas, as well as in potential processes of daily chemical exposure by the most varied sources (unhealthy environments, products and foods of daily use and consumption with undesirable levels of hazardous chemical agents or residues), explicit intentions to understand the social determinants of health, recognizing the environment as a constituent of the determinants in health–disease processes. And it favors the strengthening of the organization of users of public services through participation in the meeting with the group of narrators in which the common demands emerge as a form of interaction, collective reflection, as an encounter of opportunities for mutual knowledge between people and knowledge.

(continued)

Table 30.1 (continued)

Questions	Take-Home Messages
What others could learn with your experience? What is localized and what is "generalizable"?	Narrative meetings are inserted in the context of methodologies that favor the cultural matches/mismatches of ideas, being devices in the relationship between students and narrators, demanding active, participatory, critical, and inventive attitudes of the subjects involved (students, professors, community). The insertion of the socio-environmental health theme, which places the illness due to environmental causes with attention focused on the person (understood in their intersubjective and socially conditioned determinations), has unveiled as "localized" the polluted territories and the interactions produced and producers of narratives, and as "generalizable" the very theme of socio-environmental health and the production of narratives as a methodological strategy that enhances the meaningful and inventive learning as for the training of health professionals ethically involved, socially referenced, scientifically rigorous. Thus, a health training is constructed between the "localized" and the "generalizable," which is also epistemologically and methodologically anchored in health promotion as a formative and interventional field.

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Chapter 31
Health Education in Times of Pandemic: Promoting Health Among Indigenous Populations in the Brazilian Amazon

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Introduction

During the COVID-19 pandemic, indigenous populations have been one of the social groups most exposed to social, political, and immunological vulnerabilities, continuing until the present day, especially for indigenous peoples in voluntary isolation and recent contact (COIAB, 2020). Among the phenomena that increase these peoples' socioeconomic and health vulnerability are indigenous communities' psychosocial and spiritual fields, such as violence, the abusive use of alcohol and other drugs, and self-inflicted death (suicide). Thus, we are faced with the need to develop intercultural health education strategies from the perspective of health promotion as a collective empowerment tool for coping with the pandemic and for indigenous peoples' protection and comprehensive health care.

The Ottawa Charter associates the contemporary concept of PS with a set of values such as citizenship, development, solidarity, quality of life, democracy, social participation, and others (Brasil, 2002; WHO, 1986). It also refers to synergistic strategies, including healthy public policies, the strengthening of individual and community actions, and the development of the health system and intersectoral partnerships (Buss & Carvalho, 2009, Ordinance 2.446 / 2014, Buss et al., 2020).

The improvement of health promotion consists of training health professionals and communities to develop skills and abilities to translate theory, policy, and research in health promotion into practical actions (Battel-Kirk et al., 2009). Thus, in 2008, the Galway Conference was held in Ireland (IUHPE, 2007), which aimed to initiate the international debate to construct guidelines for health promotion and education competencies. Competence in the field of Health Promotion is defined as 'a combination of knowledge, skills and attitudes, which enables an individual to perform tasks according to a standard' (Dempsey et al., 2010).

Health promotion actions aim to increase the control of individuals over the determinants of health, and with indigenous populations, this deserves special attention. The empowerment of these peoples requires the elaboration of strategies that seek to promote their participation in the search for political representation for greater social justice and improvement in quality of life (Carvalho, 2004). It means having the autonomy to make informed choices, a primary objective of health promotion (Oliveira, 2005).

Health education concepts, methodologies, and activities can only be carried out in the context of an emancipatory health promotion strategy. This proposal involves a dynamic process of mediations and the constitution of relational, cognitive, and ethical fields, implying shared production of knowledge and practices favourable to the constitution of spaces for the achievement of freedom, the reduction of socioenvironmental vulnerabilities, and the exercise of fundamental human rights (Freitas & Porto, 2011). This framework favours actions that involve different actors and institutions responsible for promoting well-being in the 'community and environment of life and work', where preventive and educational programmes must also be placed (Lopes & Tocantins, 2012). It could protect indigenous people, the health of workers, and community leadership from promoting community well-being.

In the Unified Health System (SUS), permanent health education (EPS) is configured as learning at work, where learning and teaching are incorporated into the daily life of organizations and the protection work promoted by the National Indigenous Health Policy. EPS is based on meaningful learning and the possibility of transforming professional practices in daily work (Brasil, 2009). In this way, the health emergency caused by the coronavirus impelled health care and management professionals to invent solutions in the practice of the service, especially in a context of the absence of clear guidelines on the part of the national health authority as occurred in Brazil.

The World Health Organization considers mental health as part of the emergency public health response in the management of COVID-19 (WHO, 2020). Suppose it has been a global challenge to incorporate psychosocial support strategies in contingency plans in all countries, in a country with a territorial and cultural dimension such as Brazil. In that case, it is difficult to think that this challenge could be overcome without the participation of other actors in society and other governmental and non-governmental organizations.

The original peoples have their own knowledge about what health and disease are and how to avoid them. However, the challenge in the face of health threats is how to build preventive actions based on intercultural dialogue and with symmetry of knowledge and care practices. In this adverse scenario, indigenous populations have positively adopted strategies of resistance and affirmation of their ancestral knowledge and community self-care. Thus, it is essential to recognize the validity of traditional knowledge and the legitimacy of the performance of leaders (chiefs, specialists, midwives, and fathers and mothers of families, among others) in the constitution of the field of care and attention to the psycho-spiritual health of indigenous groups (FIOCRUZ AMAZÔNIA, UNICEF, & COIAB, 2020).

There is an urgent need for constructive and emancipatory actions to protect the cultural heritage of indigenous peoples. In this scenario, in October 2020, the Oswaldo Cruz Foundation, in partnership with the United Nations Funds for Children and Coordination of Indigenous Organizations in the Brazilian Amazon, promoted a training course in mental health aimed exclusively at mitigating the psychosocial impact of COVID-19 on indigenous populations in the Brazilian Amazon.

Thus, this chapter describes alternative educational and pedagogical strategies for conducting a collaborative training course with indigenous empowerment that brings together knowledge of traditional medicine in communities, creating viable and consensual alternatives for addressing health problems and solutions in indigenous territories in the Brazilian Amazon.

Territories and Indigenous Health Policy in Brazil

Five centuries of colonization in Brazil produced the genocide of peoples, languages, and cultures, wiping out and making the knowledge of the different indigenous peoples invisible. In 1999, the country created a specific policy for differentiated health care for indigenous peoples through the Indigenous Health Care Subsystem in the Unified Health System (SASI-SUS). The system aims to guarantee health for indigenous peoples, respecting their geographical, cultural, and social specificities. Management is carried out through the 34 Indigenous Health Districts (DSEI), which develop Primary Health Care (PHC) actions for the villages throughout the country (Funasa, 2002).

The SASI-SUS is the result of indigenous peoples' struggles to create a specific public policy for health care for the Indians. Their rights are guaranteed in the constitution, with which the process of regulating indigenous areas also began. Indigenous lands represent 12.5% of the national territory (106.7 million hectares). Currently, there are 896,900 indigenous people, distributed among 305 ethnic groups, with 274 languages. In the Brazilian Amazon, there are approximately 430,000 indigenous people (see Fig. 31.1 and Table 31.1). The majority (63.8%) still live in villages, and 36.2% live on the margins of the cities (IBGE, 2010). It means that there is great cultural, language, cosmological, and knowledge diversity. Despite this diversity, only 25 groups have more than 5000 speakers (Schweickardt et al., 2020).

Fig. 31.1 Ethnographic regions of the Brazilian Amazon, 2021. Source: Reproduced from Fiocruz Amazônia, 2021

Table 31.1 Community organizations of indigenous territories in the Brazilian Amazon, 2021

Organization	Coverage area	Brazilian state
Federação das Organizações Indígenas do Alto Rio Negro (FOIRN)	Alto Rio Negro	Amazonas
Conselho Geral das Tribos Ticuna (CGTT)	Alto Rio Solimões	Amazonas
Associação Yanomami do Rio Cauburis e Afluentes (AYRCA)	Alto Rio Negro	Amazonas
Conselho Indígena de Roraima (CIR)	Leste de Roraima	Roraima
Manxinerune Tsihi Pukte Hajene (MATPHA)	Alto Rio Purus	Acre
Federação dos Povos Indígenas do Pará (FEPIPA)	Guamá-Tocantins	Pará
Articulação dos Povos e Organizações Indígenas do Amapá e Norte do Pará (APOIANP)	Parque Tumucumaque and Paru D'Este	Amapá and Pará
Federação das Organizações e Comunidades Indígenas do Médio Purus (FOCIMP)	Médio Rio Purus	Amazonas

Source: Fiocruz, 2021

Each indigenous person understands the body, origin, and cause of diseases, therapies, and health care. Therefore, multiprofessional health teams are committed to responding to the needs of the indigenous peoples, respecting their forms of care. Along with the official health policy, there is the role of shamans who carry out the healing process through a broad knowledge of nature and cosmology, being an intermediary between human and non-human beings. The traditional knowledge of shamans has been necessary facing COVID-19, giving hope to indigenous peoples in the face of government neglect.

Mental Health in the Indigenous Context

Mental health is a concept that goes beyond objective and simplistic understandings of simply the absence of psychological suffering, exceeding the understanding of psychopathology and semiology, and surpassing biomedical reductionism. The term refers to shared care and the subject's harmonic and well-being state in the search for the individual's autonomy (Amarante, 2007). Therefore, we focus on the concept of psychosocial care that considers the person, their relationships, the context, and the culture to understand the whole related to suffering and favour expanded care (Yasui & Costa-Rosa, 2008). The scope of the term Psychosocial Support is even more evident in the context of emergencies and disasters as it recognizes that the responses needed to mitigate the adverse effects and create positive alternatives in the face of such events overcome issues of an individual nature but rather that they need to be produced by collective action, through government actions or community-based mobilization.

Traditional peoples use the expression 'Bem-Viver', which translates the logic of extended care, briefly translated as a good way of being and living. This concept

represents the wisdom of the indigenous peoples and refers to the relationship between all beings on the planet, with 'culture and nature merged into humanity' (Fleuri, 2017, p. 285). Thus, it can be reflected in the daily practice of coexistence, respect, joy, food, spirituality, and balance between everything and everyone.

It should be borne in mind that the health–disease process is understood from the cultural perspective. For this reason, interventions need to consider the considerable knowledge of the individual and the collective to be effective, which, at the same time, also starts from the subject (FIOCRUZ AMAZÔNIA, UNICEF, & COIAB, 2020). With the advent of COVID-19, several vulnerabilities of traditional peoples were increased, from socioeconomic to health, requiring more outstanding care and attention from public spheres on several fronts, including well-being, mental health, and psychosocial care.

Psychic suffering is multicausal, and in the pandemic context, it was aggravated due to the restriction in physical contact and coexistence in large groups, impairment in the performance of funerary rites that include strategies to face the loss, and mismatched information about the SARS virus CoV-2 and COVID-19 disease (FIOCRUZ AMAZÔNIA, UNICEF, & COIAB, 2020). Rapid response in health emergencies requires, in addition to actions based on scientific evidence, a strategy for translating knowledge capable of producing syntheses and presenting knowledge in friendly formats, simple language, and with direct messages (KABAD et al., 2020). Therefore, a course was prepared, and all material was produced by indigenous teachers and researchers in education and health. This effort was made to recognize the importance of indigenous knowledge and self-care practices in comprehensive health care for communities facing the pandemic.

The Bem-Viver Course and the Teaching-Learning Model

The Bem-Viver: Indigenous Mental Health course arose out of the need to reduce the psychosocial impacts caused in the communities of people originating in Brazil caused by the SARS-CoV-2 virus (COVID-19) in their territories. It aimed to contribute to the training of various health, education, and social assistance professionals who work with indigenous populations directly affected by the pandemic and to help them develop psychosocial support and protection strategies for children, young people, and their relatives.

The course was designed in a self-instructional format. All students could access the materials according to their time available, conditions of access to the Internet, and pace of learning. It was divided into six modules, the first being a general introductory module, and the others focused on specific subjects that deal with different aspects of mental health.

The material addressed essential issues for understanding and constituting support networks and facing psychological suffering in indigenous communities. The entire course was produced with care in dialoguing and legitimizing indigenous knowledge and its collective coping strategies about health, disease, and ancestral

knowledge. The proposal was to treat all this knowledge equally with non-indigenous Western knowledge in the ecology of knowledge in intercultural dialogue.

The course was made available through the virtual learning environment (VLE) for professionals in the health, education, assistance, and indigenous social protection, as well as community leaders and young indigenous communicators with subsidies, to work in mental health care and psychosocial care in their communities.

Distance education within the pandemic context provides the connection of a more significant number of people anywhere in the world. However, one of this modality's difficulties is the absence of a humanized pedagogical accompaniment that understands the specificities of the places. For this, the course had the support of four tutors who favoured efficient pedagogical monitoring so that the proposed educational objectives were achieved. Each tutor accompanied a group of students from two priority regions, with the responsibility of helping to overcome difficulties in accessing didactic material, the digital platform, and any doubts about the subjects covered in the course.

To cope with the new needs that arise with distance learning, the teacher needs to seek dialogue with students, the curriculum, information, and with themself. Rethinking practices means seeking the answers to new needs in ontogeny, reflecting on being a student and being a teacher, in the culture of teaching and the culture of learning (Trein, 2008). Thus, tutoring was designed so that there was respect between intercultural dialogue, and the majority of students were of different indigenous ethnicities who work in some way within their communities. This strategic tutoring design was provided since the conception and construction of the material, being able to point to new dialogues about how this action should occur in distance education courses, its relevance within the objectives of the course, and provision of a general notion of what would be addressed in each module.

The course lasted six weeks and had the active participation of indigenous teachers from the Mura, Tuxá, Xukuru, Tikuna, Macuxi, Tukano, Tembé, Nambikwara, and Munduruku ethnic groups. These are professors from various fields of training, including psychology, anthropology, health, and education. The contact with the collective construction of the material allowed different views on the same subject to reveal the truth about the aspects surrounding mental health and its implications for communities.

In the introductory module, the guiding elements for understanding the entire course were exposed, including the valorization of indigenous knowledge and the decolonial perspective as the guiding axis of the materials. The specific modules, on the other hand, addressed the themes of greatest vulnerability, within the scope of mental health affecting the communities, such as (1) Self-care and Community Strategies, which highlights the primary means by which communities deal with the diseases that arise in the territories; (2) Children, Youth, and Elders, which addressed the concept of a person supported by kinship relationships and community life, guided by the different traditions and rituals of passage experienced by peoples; (3) Violence, which highlighted the historicity of the phenomena of genocide, ethnocide, and epistemicide that plague indigenous territories; (4) Alcohol and Other Drugs, which dealt with the different ways of understanding the phenomenon within

the communities, highlighting dialogue as a guiding element of health strategies for professionals who work in these places; and (5) Suicide, which uniquely highlighted the suffering of communities through the reduction in territories and constant threat from the western world over indigenous communities.

Of the total number of individuals enrolled on the course, students from priority areas directly monitored by tutors represented 21%.

Digital Information and Communication Technologies – TDICs in education aim to promote students' collaborative skills, teaching, and learning. The Fiocruz Amazônia platform has always used the virtual campus, but with the course, we worked unprecedentedly with the Virtual Learning Environment (VLE). This platform is our 'main' tool, where all students need to register and follow all modules (disciplines) of the course, as shown in Figs. 31.2 and 31.3.

In this virtual learning environment (VLE), students had access to written and audiovisual materials, polls, an activity calendar, interaction space, support material, progression of each module, certificate, and technical support, if needed.

Each week, the booklets and the videos classes were posted in the virtual learning environment. In the end, the students who had achieved 75% of success in the course answered the evaluation questionnaire, allowing access to the certificate. The preference for the weekly time interval between modules was fundamental. It allowed students residing in areas with difficulty accessing the Internet to download materials with the necessary time to keep up with the course's pace.

In addition to the virtual learning environment, we used technological support tools, thinking about accessibility and the best way to reach the students, helping in the teaching and learning process. WhatsApp also functioned as a forum for

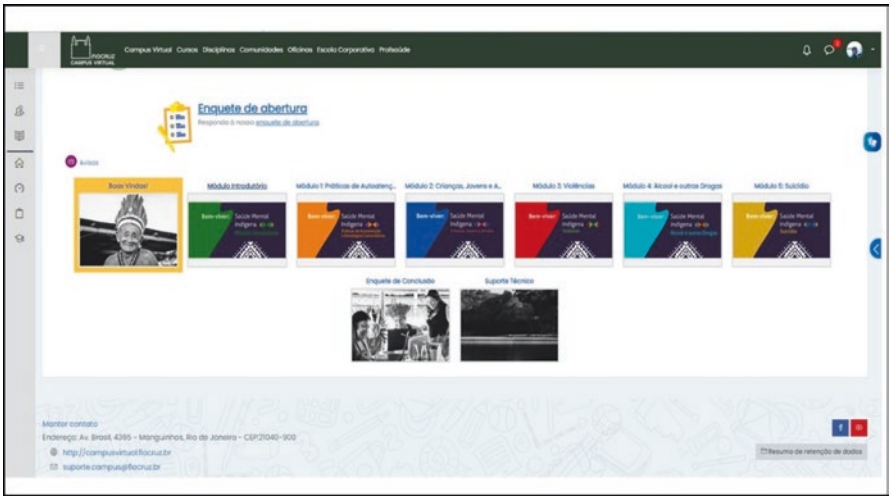

Fig. 31.2 Presentation of the Virtual Learning Environment – VLE, 2020–2021
Source: Reproduced from Fiocruz Amazônia, 2021.

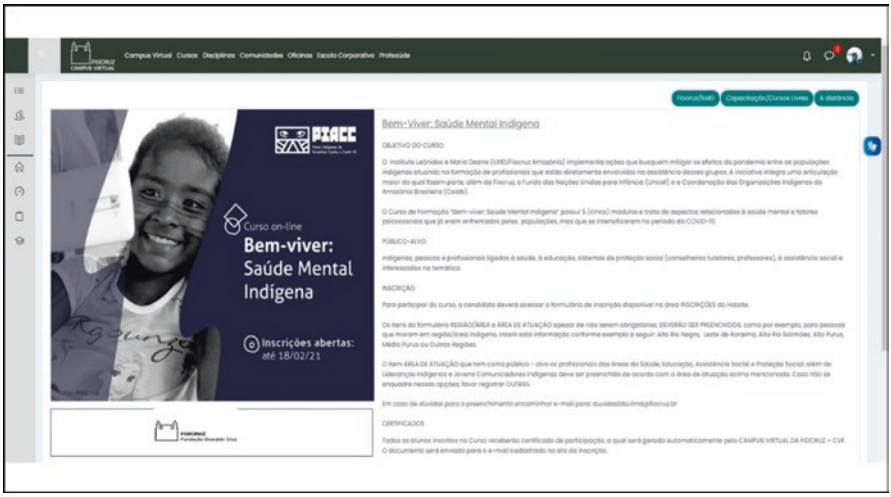

Fig. 31.3 Bem-Viver Visual Training Platform, 2020–2021. Source: Reproduced from Fiocruz Amazônia, 2021

interaction between the students themselves, technical support, and assistance provided in a personalized way.

Another communication tool used was electronic mail, which was available throughout the course so that all enrolled students could send their questions. The pedagogical tutors compiled the questions that arrived both via WhatsApp and email and forwarded them to the teachers to be answered within 48 hours.

When examining the content of the comments in the interaction with the students, it was noticed that the video classes were better used than the printed material in the format of booklets. Thus, it is suggested to use another media resource in addition to those already available on the platform: the production of podcasts.

In the podcast's production, summaries of the main subjects covered by the booklets were recorded, generating five episodes, with a time variation between 30 and 50 minutes of audio, depending on the episode. All audios are available for free on Spotify's streaming platform, through the COIAB channel (Coordination of Indigenous Organizations in the Brazilian Amazon) with the same title as the Bem-Viver: Indigenous Mental Health course.

Evaluation of the Teaching-Learning Model

The occurrence of the pandemic has affected the indigenous territories in a fulminating manner. The increase in the number of indigenous people affected by the disease has generated significant cultural and social impacts in their territories. The absence of coordinated health measures has also had implications for health

services, requiring effective social actors to find viable alternatives to mitigate the effects of COVID-19 on indigenous communities. Activating groups or platforms for rapid response in emergencies in public health represents a challenge and, at the same time, an essential element for the provision of relevant and high-quality evidence in a short period (El-Jardali et al., 2020).

In total, 2540 people enrolled on the course from 507 municipalities in all states of Brazil, the majority of whom residents in the Brazilian Amazon region. Among the indigenous villages were 38 inscriptions from the territory of Parque Tumucumaque and Paru D'Este, 178 from the territory of Guamá Tocantins, 221 from the territory of East Roraima, 53 from the territory of Alto Rio Negro, 39 from the territory of Alto Rio Solimões, 61 from the territory of Alto Purus, 22 from the territory of the Middle Purus, and 10 from the territory of the Yanomami region, totalling 622 enrolments or 24.6% of the total course participants. In addition, the course attracted students from other countries such as Canada, Italy, South Africa, Colombia, Peru, Germany, Chile, Uruguay, and the United States.

Despite the connectivity difficulties in the region, the choice for the distance learning and self-instructional format was primarily due to its low cost and speed in providing content to those professionals. They live in areas and municipalities that are difficult to access and present few opportunities for offering face-to-face courses (Oliveira, 2007). Second, it is due to the ability of this type, of course, to reach a more significant number of people in a short time, generating the acquisition of knowledge and skills from the development of critical-reflexive capacity for the development of actions in the short, medium, and long term (Silva et al. 2015). Third, in the current context of health emergencies and with the possibility of the collapse of health systems, the self-instructional course fulfils the role of autonomy in updating and transforming health care as the primary strategy of managers and leaders to act in the rapid response to problems in mental health.

It is worth noting that the possible difficulties that people may have faced when accessing the course relate to little familiarity with the use of the available technologies, especially in accessing the VLE platform, particularly difficulties regarding search autonomy. This point was minimized using the WhatsApp application and mediated by the course tutors who were instrumental in facilitating students' learning, monitoring, and support. The performance of this team made it possible to overcome the difficulty of connecting to the Internet, as the materials were made available directly to course participants within the WhatsApp group.

The contents made available included the videos in a compressed format file and the booklets in PDF format. Seven videos were produced on the themes chosen by the indigenous people and made available on the YouTube platform. The length of the videos was 20 to 30 minutes, and the booklets were 20 to 30 pages. The use of WhatsApp facilitated access and favoured the sending of files quickly.

The group's virtual environment in the WhatsApp app allowed for something like a virtual classroom or a digital class. This created a community environment where course participants could exchange ideas, post observations about the course, and discuss topics among colleagues. Thus, the course was a process of building community knowledge through the communication channel formed by students.

The tutors mediated the exchange of knowledge through the content covered during the training. Another relevant role of tutors was to mediate between course participants and teachers. Since the course was self-instructional and, therefore, with no live classes, there was no provision for dialogues with teachers who were also indigenous. Complimentary comments on the materials, doubts, and interesting questions arose from the course participants that were put to the tutors. The tutors participated in the group of teachers and contacted them so that these exchanges were carried out spontaneously. Thus, the teachers answered the students or indicated complementary materials.

Even though the course provided materials that were easy to understand and disseminate, such as videos, there were also booklets with theoretical depth, demanding extensive reading. We knew that the videos would probably be more fully assimilated since the booklets required much reading. For this reason, a fundamental strategy was to also make the booklets available in the form of a podcast, making their assimilation fully viable.

The tutors' role was to read the booklets aloud, making a kind of audiobook, when recording podcast episodes. The podcast format was very suitable because it was more pleasant and relaxed and had the help of indigenous teachers of different ethnicities. Thus, the course contents managed to be fully disseminated among all the different participants with their respective educational or digital literacy difficulties.

The option to broadcast podcasts is available on streaming platforms through the Confederation of Indigenous Organizations of the Brazilian Amazon (COIAB) channel, allowing people who already listen to this organization's programmes to be heard on their Spotify channel. Naturally, the course participants received the podcasts in the MP3 file in the same WhatsApp groups. In addition, the dissemination of these materials by podcasts enabled the course contents to be disseminated to several other distant indigenous ethnicities who did not participate in the course. Thus, the specific productions of this course could be made available to all communities that are part of COIAB throughout the Brazilian Amazon. We can consider that this was the legacy and social benefit of the course for indigenous populations across the Amazon.

Therefore, the diffusion's course can be attributed to how the tutors worked with the students in the sense of being pedagogical support that compensates the digital inequalities to which these populations are victims. Each student was an instrument of pedagogical support that explains the success of the course. Just as important as the role of the tutors was the adaptation of the contents using viable means of dissemination: booklets, videos, and podcasts. The booklets ensured a secure academic record, with great theoretical depth, which is easy to use later, particularly for indigenous health professionals. The videos complemented the contents of the booklets, exemplifying through concrete cases and using testimonies, narratives, and characters to illustrate the realities discussed in the course. On the other hand, podcasts allowed complete assimilation of the theoretical material in the booklets by all course participants, from the highest educational level students to subjects with

little literacy in the Portuguese language but who were able to understand the audio-narrated version fully.

Conclusion

The development of intercultural health education strategies to better face a COVID-19 pandemic considered the cultural, socioeconomic reality, which presents practical solutions and specific approaches in the context of the Brazilian Amazon.

In short, the creative methodologies developed in the course were the alternatives found to promote the encounter of traditional and non-traditional knowledge and to produce health protection in indigenous territories. It was possible to observe the development of consistent teaching and learning processes that dialogue a lot with the principles of reinforcing the autonomy of students and teachers and individual and collective empowerment that concern the production of singular knowledge through a glocal approach.

One of the structuring axes of the entire course was supported by bringing reflections on the development of people from the perspective of indigenous knowledge while also strengthening the sociopolitical organization of the communities. This way of building knowledge allowed professionals, who work in these contexts, to build, together with communities, strategies that favour practices that are more oriented toward ethics and intercultural dialogue. It is known that many practices of these professionals have gaps, either in initial training or in intercultural dialogue with indigenous communities, distancing people from what Walsh (2007) calls critical dialogue, capable of proposing an alternative political position to hegemonic geopolitical practices through cultural, social, knowledge-building, and power distribution.

This ordering conception of the proposed articulation of knowledge triggered the concept of glocalization, elaborated by Robertson and refined by Beyer, Roudometof, and Vásquez, which highlights the relationship between the global and the local (Beyer, 2011). That means addressing the presence of a local dimension in the production of a global culture. Roudometof (2016) explains that in the 'glocal', the 'local' would represent the 'we' in the global expression, including even the resistances, that is, the contributions of local and regional identities to globalization. Thus, we can infer that the articulation of diverse knowledge produced individual and collective empowerment of the original peoples of the forest through the course, providing a local response to protect life in the face of a threat to global health. Experiences like this can be replicated in rural and socially vulnerable areas anywhere in the world, depending on the human resources involved.

The social history experienced by indigenous peoples during the pandemic of the new coronavirus shows a humanitarian crisis. There is a need to create devices that assist these populations' interests and guarantee the promotion of rights and equality between knowledge and practices, socially and politically repositioning and

empowering the indigenous person and communities in the construction of the affirmation of their ways existing.

The experience with the Bem-Viver: Indigenous Mental Health course provided professionals and community leaders with the opportunity to access knowledge and practices oriented to the local reality of each community. It is essential to break with actions aimed at reproducing devices that continually reinforce the logic of industrial societies. The construction of intercultural dialogues proposed in the course proved to be a promising form of more symmetrical relationships between scientific and traditional knowledge. It has to favour health promotion in its most fundamental principles, which are the mediation of relational, cognitive, and ethical fields between people and communities in the shared production of knowledge to reduce the vulnerabilities of indigenous territories.

It was possible to rethink pedagogical practices, technological tools, the student's culture, the curriculum, and the social environment. This sensitivity demonstrates respect for different cultures, ethnicities, and languages, highlighting intercultural dialogue. In this sense, the sensitivity of the coordination of the course and the pedagogical tutors in adapting and bringing new educational and technological resources, even after the beginning of activities, illustrates that the teaching and learning process is constantly changing.

Another highlighted aspect is the ability to create materials and methodology oriented to dissolve a dominant and westernized epistemological conception, mainly in psychology and mental health. The scarcity of productions exposed the professional's fragility and the distance from the reality of the communities, evidencing practices in disagreement with the well-being and empowerment of people. In this sense, the experience in the production of booklets and video classes favoured an epistemic and methodological tuning with people and communities, listening and dialogue as mediators of practices and constitution of care networks.

It is imperative to say that the production of participatory and integrative methodologies in permanent education for indigenous health and social protection workers summoned the knowledge of traditional medicine in the communities, creating viable and consensual alternatives for addressing their health problems and solutions. Above all, there was the meeting of traditional and non-traditional knowledge as an immediate health response to mitigate the impacts of the pandemic in these communities. Technological tools have been the greatest ally in the educational field in times of pandemic, and the completion of the course represented the emancipation of indigenous peoples. It evidenced the construction of new knowledge about COVID-19 in the promotion of self-care and the autonomy of the indigenous people for the decision-making of healthy choices that protect life in the indigenous villages.

Finally, it is possible to conclude that the health education approach used and the empowerment of indigenous populations in the Brazilian Amazon to face COVID-19 are following the principles and competencies of health promotion. Here, the mental health promotion course was prioritized, and interculturality was taken into account in strengthening the autonomy of multiethnic indigenous peoples.

Table 31.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 31.2 Authors´ reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion is developing the capacities and autonomy of individuals and social groups to decide on healthier choices. The experience presented recognizes the subjectivity of indigenous people and health and education professionals and the care process in defence of health and life through an online course.
What is the institutional and political context of your experience (participants, professions and courses involved, duration, and frequency of activities)?	Professionals from different areas of anthropology, psychology, education, philosophy, medicine, social assistance, linguistics, and professionals from public health, mental health, and indigenous leaders have participated. The pedagogical core was composed of indigenous and non-indigenous teachers who took on the roles of content teacher, intercultural reviewer, and pedagogical tutor. Activities took place weekly from January to March 2021.
Which theories and methodologies are used in the teaching-learning process?	The teaching-learning process used the eLearning and self-instruction model based on pedagogical, dialogic, and intercultural principles. Discussion groups via WhatsApp coordinated by pedagogical tutors were also used. This strategy allowed for the generation of new possibilities and the necessary flexibility to conduct a collective teaching-learning process that dialogued with the cultural diversity of the communities.
What forms of assessment are applied, results achieved, and challenges faced?	There were 2540 indigenous and non-indigenous students. The participation of municipal health, social assistance, tutelary councils, and special indigenous health districts (DSEI) from all states in the northern region of Brazil was evident, with the highest percentage of course graduates coming from priority areas. The digital divide and limited connectivity were the main challenges. However, the Bem-Viver: Indigenous mental health course proved to be an essential experience in decolonizing knowledge and promoting the autonomy of indigenous individuals and groups.
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The experience adopts principles of equity, social participation, autonomy, empowerment, intersectionality, sustainability, integrality, and territoriality. The chapter described the processes of education, professional training in health promotion for workers, managers, and citizens. The teaching and learning plan was based on the development of spaces for social production and healthy environments, favourable to human development and Well-being, on the appreciation of popular and traditional knowledge and the promotion of empowerment and the capacity for decision-making and the autonomy of individuals and communities, through the development of personal skills and competences in promoting and defending health and life.
What others could learn with your experience? What is localized and what is 'generalizable'?	We have learned from experience that it is possible to carry out health education to promote mental health in multiethnic indigenous populations in remote areas of the Amazon. All the experience and teaching and learning strategies adopted can be generalized and applied in several remote world areas.

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Chapter 32
Health Promotion and Working in/with Groups: An Experience of Interprofessional Training at UNIFESP Baixada Santista (Brazil)

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Contents

The experience reported herein was produced through dialogue between the teaching-learning process in health promotion and the challenges posed by interprofessional training for undergraduate students of occupations in the health field. We

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share methodological teaching strategies so that this local experience can be developed in other situations with other groups.

Background: The Health Work

The educational experience presented here was conceived from the encounter among important collective movements that gained strength in Brazil in the first decade of the century, resulting in the expansion of access to public higher education, which was an accomplishment stemming from the historical struggle for the democratization of the right to an education in the country. Concomitantly, education in the health field was undergoing a reorientation process to give undergraduate students a closer look at the complexity of practices of the public healthcare system and the needs of the Brazilian population.

The *Baixada Santista* campus of *Universidade Federal de São Paulo* (UNIFESP/BS) was created in 2004 as the first campus founded during the expansion of Brazilian federal universities. UNIFESP/BS initially offered courses in the health field (physical education, physiotherapy, nutrition, psychology, and occupational therapy), adding a social service course in 2009. This event was also promoted by the collective, coordinated organization of various social actors of the metropolitan region of Santos,[1] who had long demanded the implementation of a public university in the region. This expectation was directed at the UNIFESP/BS since its inception to meet the needs of the local population and rise to the challenges of expanding the right to higher education in Brazil (UNIFESP, 2006).

Throughout the implementation of UNIFESP/BS, a political choice was made toward creating an innovative political-teaching project in line with national and international discussions on the challenges faced by contemporary universities, namely, to contribute to the production of meaningful knowledge in dialogue with different social actors, renew teaching practices, and contribute to a reduction in inequalities, thereby addressing both local and national issues. There is a growing expectation that universities should, according to Bizerril (2020), "assume a key role in the process of transformation of society to higher civilizing levels" (p. 10).

The guiding principles of the UNIFESP/BS political-teaching project are also aligned with critical analyses directed at questioning the predominant form of educating healthcare providers since the second half of the twentieth century. Such analyses point to the need to overcome the "fragmentation of knowledge and practices [as well as] technification [and] reductionism in approaches to the

[1] Metropolitan Santos is located on the southern coast of the state of São Paulo and is composed of nine municipalities—Santos, São Vicente, Cubatão, Bertioga, Mongaguá, Praia Grande, Guarujá, Itanhaém, and Peruíbe. It covers an area of 2373 km^2, with a resident population of 1,781,620 (IBGE, 2014). It is estimated that about 300,000 people of the region live in substandard communities (SÃO PAULO, 2010). A road network (Anchieta Roadway, Imigrantes Roadway, Rio-Santos Highway, Padre Manoel da Nóbrega Ariovaldo Almeida Viana Highway) allows intermetropolitan access and connects the capital to other cities in the state, enabling regional tourism and the outflow of goods from the Port of Santos while also accentuating social inequalities.

health-disease process and the distancing from the health needs of the population and the healthcare system …" (Capozzolo, 2017, p. 68).

To promote health education in line with comprehensive care, teamwork, and the complexity of the health-disease-care process, we opted for an interprofessional, interdisciplinary design based on integration with the community, directed actions, student participation in knowledge building, and the inseparability of teaching, research, and community outreach (UNIFESP, 2006). Guided by such principles, a complex curricular architecture was outlined, concentrating efforts to overcome discipline-centric thinking focused on specialties toward a teaching-learning process common to the six courses offered and operated with mixed classes of students and professors. The curricular structure is organized along four axes: (1) Approach to a specific practice in health offered to students in a specific professional field; (2) the biological dimension of human beings; (3) social context; and (4) health work.

The guidelines of the Health Work Axis and its component "Teamwork and Collective Practices" module, which we will discuss in this chapter, are to incorporate and put into practice the desired changes in the health education process through inventive training focused on experience as well as encounters with people, groups, populations, and service networks. The Health Work Axis:

> [...] understands health education as a process of social practices permeated by conceptions of health and illness. It seeks to overcome reductionist conceptions and their linear causal relationships and contribute to establishing an academic culture that is nurtured by uncertainty, dialogue among different people, the broadening of paths for the production of scientific knowledge and the plural perspective of knowledge and human experiences (UNIFESP/BS, 2006).

The educational pathway of the Health Work Axis is structured in five modules[2] that cover the first three years of undergraduate study to promote the engagement of students in activities involving the network of services that enable contact with different population groups in metropolitan Santos. The ways of life and work of individuals and families are respected. Moreover, teaching and community outreach activities are integrated with public services as well as the different forms of organization among staff members and residents. Thus, these outreach activities, which were traditionally designed to bring the university closer to its surrounding social context, have been incorporated into the activities of the Health Work Axis.

Each of the five modules has its own way of functioning, and the number of classes varies according to the number of students enrolled in the courses. We have about 40 faculty members and approximately 700 students each semester. Thus, the same module is taught by different faculty members at the same time, but the professors try to establish common guidelines and content to guide them. Efforts are made to ensure a proportional number of students, always equally mixed among the different courses to generate interdisciplinary movement, which is guided by the

[2] The five modules are (1) Living Conditions and the Social Production of Health; (2) Social Inequality and Health Policies in Brazil (both of which are offered to freshman of all courses); (3) Encounters and the Production of Narratives (offered to second-year students of all courses); (4) Teamwork and Collective Practices (also offered to second-year students, except for those in the Social Work course); and (5) Integrated Clinic/Production of Care (offered to third-year students, except for those in the Social Work course).

following question: “What should all healthcare providers know regardless of their specific field of training?”

These activities also involve providing opportunities for interdisciplinary cooperation among professors as well as a pact with teams from different public services (health, education, social assistance, and sports), nongovernmental organizations, and other institutions in metropolitan Santos. As a principle for this training, we assume interactions with situations experienced in the daily practice of different fields of care articulated with the theoretical-methodological references of each module. This process begins with the first module and is intensified: “we bring into the educational process the affections, sharing, anxieties, fears, frustrations, (...), articulating theory, practice and experience” (Capozzolo et al., 2013, p. 444).

Our definition of experience does not conform to the usual conception of knowledge baggage acquired throughout the course of life, but of assuming risks and taking from both present and past experiences. According to Bondía (2002), the subjects of experience are those who take chances “in a real world with its contradictions – uncontrollable and in permanent flux” (p. 24). Experience takes place in alliance with life where it happens—at services, in the most vulnerable regions, in the streets—creating encounters in order to give rise to interdisciplinary and interprofessional work with multiple forms of knowledge. Knowledge from different fields has a place in this project but is not central; we also value collective creations produced in the act—in a common clinic that is constructed in a processual manner in the training course and in the communities of those involved.

When talking about interprofessional training, it often seems to be enough to organize groups/classes composed of different fields of knowledge in order to solve all problems. However, as Capozzolo et al. (2018) ask, “how to deal with the tendency to cut and interpret the demand brought by an individual according to the frame of reference of the professional field?” (p.1679).

Therefore, we place our bets on the notion of interprofessional cooperation that results “from encounters involving specific professional knowledge but also, and especially, those legitimized by singularities and events,” as situations that arise in everyday life crosscut both disciplinary and professional boundaries (Henz et al., 2013, p. 167). Capozzolo et al. (2018) state that “the ‘object’ of each health profession does not coincide; therefore, it is not enough to put them together to be able to compose a lost unity” (p. 1677). This summons us to open ourselves to the “interdisciplinary,” of that which is not given, a place for not knowing but which can be produced in act (Merhy, 2002).

This path requires work combining field and classroom activities that do not necessarily take place on campus. Theoretical and methodological discussions are provided with the support of texts and films, which serve as tools to be used during field activities. After each field activity, the students are asked to make individual entries in personal journals, describing their experiences and the marks left by them. Upon return from field activities, there are moments of supervision to process, discuss, problematize, and give a certain outline to what was experienced. This is an important time to listen, reflect, and articulate concepts of theories and practices in light of the experiences (Capozzolo et al., 2018; Azevedo et al., 2017).

This way of operating—of putting the modules into operation—maintains us in a constant process of reflection-action-reflection with what we experience in the classroom and field together with students, healthcare providers, and administrators, because it is a living, breathing education that accompanies the movements of the communities in which life takes place.

In this training context, the Teamwork and Collective Practices module proposes to strengthen learning to work with groups in order to form interdisciplinary teams of students and enable the exercise of common collective practices. Two dimensions based on the health promotion framework are prioritized in this process: teamwork and collective action in the community and/or with population groups.

However, the process of putting these dimensions in the field and promoting teamwork runs against the hegemony of individual work and the specialism of each field. It places on the agenda the challenges of interprofessional cooperation, the difficulties and potentialities of the collective dimension of health work, and the complexity of health promotion (Azevedo et al., 2017).

Like others in the course, this module is executed by several professors who have experienced diverse training processes. This necessarily implies an intense dialogue before, during, and after the module takes place each semester, which is also a considerable challenge both for the students and professors in the relationship with the population groups involved.

Methodology of the Teaching-Learning Process: Concepts and Experiences in Forming and Being a Group

The experience of the Teamwork and Collective Practices module has been going on for 14 years[3]—time required for the development and consolidation of a teaching method to support the concepts covered and the objectives to be reached with the proposal.

The teaching-learning process for team and group work is anchored in the concept of health promotion, which relates health to the social determination of living conditions, highlighting collective participation and individual skills as essential factors for the construction of a healthy life (Czeresnia, 2003).

To this end, the first principle of the training resides in the construction of work in and with groups, that is, the importance of establishing "groupality" as a central element of the work. Groupality regards experience that is not reduced to a set of individuals and can also not be taken as a unit or immutable identity. It is a collective or a multiplicity of terms (staff, users and administrators of public healthcare services, families, etc.) in agency and in transformation, composing a network in

[3] The process reported in this text refers to the period starting in 2007 and preceding the Covid-19 pandemic. During the pandemic, the module had to be adapted to a remote format, while attempting to maintain the same objectives. As it does not meet the objectives of this chapter, this experience will not be covered here.

which the production of health and subjectivity takes place (Brasil, Ministério da Saúde, 2010, p.19). Understanding experience as "what happens to us, what touches us" in the relationship between knowledge and concrete life, experience is adopted as the second principle of interdisciplinary training in the belief that it is through experience that knowledge and actions are consolidated (Bondía, 2002, p. 26).

The structuring of the teaching-learning process occurs in stages that are sequenced throughout the training. The stages are composed of the following: (1) initial training and the construction of groupality; (2) knowledge of communities and population groups; (3) creation of the action plan; (4) development of group/experience workshops and supervision; (5) drafting of field journals; (6) and sharing of experiences and presentation of "Experience Book."

The evaluation of the teaching-learning process is continual throughout the development of the module. This process includes evaluations of participation in the seminars, the field journals turned in after the workshops, and the "Experience Book" presented at the end of the module. Throughout this process, the students receive feedback on the actions and experiences in the form of supervision and roundtables, during which they can dialogue with faculty members regarding their learning experience. Moreover, the health work module enables an overall evaluation of all modules through the application of questionnaires at the end of the semester addressing all aspects of the training process, such as content, facilitating aspects, and difficulties encountered.

Initial Formation and Construction of Groupality

The first meeting between faculty and students is to present the teaching plan, the objectives and strategies of the module, and the concept of groupality, enabling us to recognize the commonalities and differences in our experiences as well as establish listening and care with whom we will constitute a working group (Azevedo et al., 2017).

In general, the module has nine professors from both the Health Work Axis and specific axis. Each professor works for 16 weeks with a mixed group of 10 to 15 students from the 5 health courses as a way to ensure interdisciplinarity. The first four weeks are dedicated to the construction of group work between the professors and students and the discussion of the theoretical framework. During this process, seven main points are addressed:

1. Concept of group (Casetto, 2013);
2. Concept of health promotion (Czeresnia, 2003);
3. Concept of experience (Bondía, 2002);
4. Principles of popular education (Freire, 2007);
5. Principles and pitfalls of the ideology of competence (Chauí, 2014);
6. Guidelines for building an action plan (Casetto, 2013);
7. Journal and "experience book" (Pezzato, 2016).

The framework for the theoretical approach is shaped as seminars and roundtables, which take place at the same time as group dynamics to experience situations that enrich the dialogue. The seminars and group dynamics take place in the classroom and are chosen according to the students' need to accumulate the knowledge necessary for them to conceive, make, and live the group. The particularity of the proposed seminars differs from traditional formats, as the proposals for discussion can rely on artistic expression (music, dance, theater, photography, etc.), giving more opportunity for the use and development of creativity.

In addition to this organization, another strategy to promote interdisciplinarity and group building involves seminars with two groups of students in the same classroom with their respective professors in charge. The students are divided into four or five groups based on the number of texts on which to work, and each group is responsible for proposing a seminar of the respective text. This strategy enables greater reflection on the potentialities of the group approach.

After this first division, each group is internally divided into four subgroups that have different roles in the planning and execution of the seminars—leading the discussion, forming questions, answering questions, and performing the synthesis of the discussion. Every week the subgroups take on different roles, enabling experience in each position, as illustrated by Fig. 32.1.

The professors play the role of mediators of the discussions and assist, when necessary, in the clarification of doubts, the refinement of arguments, and the organization of the synthesis.

Together with the seminars, group dynamics are proposed to favor the construction of groupality. There are a total of four group dynamics, which are described in Table 32.1.

Knowledge of Communities and Population Groups

The field meeting is the second stage of the training process and is where students get to know the population group with which they will work as well as the community in which these people live. The staff at the reference service—health, social welfare, education, etc.—present to the students the living and health conditions of the community. This is an important moment of listening and interaction, as this is the basis that will enable students to reflect on the expectations and needs of the population group with which they will work. It is also from this first situational assessment that they prepare the proposal for an initial activity to introduce themselves and get to know the group.

The second trip to the community constitutes the time to meet the population group as well as an opportunity to improve listening and observing. This is when students begin to perceive not only what is said, but also what was made clear in the discourses and actions of people regarding the group's expectations for health promotion. This is the second step of the situational assessment and is shaped throughout the meetings.

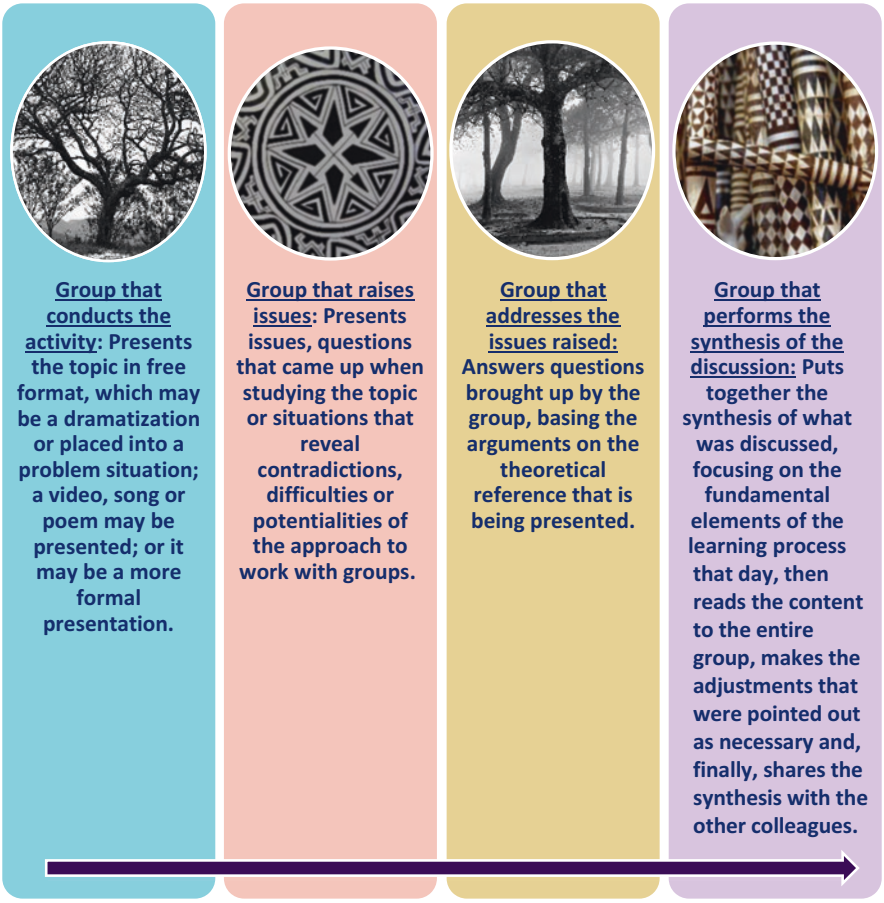

Fig. 32.1 Distribution of work by subgroups according to roles and sequence in preparation and execution of seminars of Teamwork and Collective Practices module, UNIFESP/BS, Brazil, 2021

Getting to know the community is also part of cultivating a more refined look at where and how life happens (Santos, 2004). Each trip to the field reveals another aspect not previously seen, helping promote reflections and make connections about ways of being born, living, getting sick, and dying in the community. This more sensitive look on the part of the students will appear during the training journey in the writing of the field journals.

> *We left the unit towards the cultural center, which was quite close. I noticed that the houses were very small, masonry and one right up against another (...) The health agent commented (...) that each house is actually more than five homes (...) where various families lived. I wondered how it must be to live in that tight spot, going up this big hill.* (Student journal, 2017)

Table 32.1 Triggers and objectives of group dynamics used for construction of groupality in Teamwork and Collective Practices module, UNIFESP/BS, Brazil, 2021

Trigger	Objective
What do I bring to the group and what do I expect from the group?	Work on the aspect that everyone has something to contribute, know abilities, potentials, and limits of colleagues as well as their expectations with regards to the collective of which they are part.
Analysis of "Miguel's Case" from fragments of an event in his life (Sales, 2010).	Provoke reflections on interdisciplinarity. The purpose is to recognize and deconstruct the facility that human beings have to judge and evaluate a situation from their point of view, stimulating a broader vision and qualified listening in order to have a clearer understanding of a situation or event.
Analysis of the painting *The Raft of the Medusa* (Jean Luis Théodore Géricault, 1819, Louvre salon de 1819. Accessible in: https://pt.wikipedia.org/wiki/A_Balsa_da_Medusa	Address the possibility of analysis from different perspectives in a group scene, work with the conflict of different perceptions of a situation or group event in a purposeful, integrating way[a].
Group body practice	Experience health promotion in group, stimulate the perception about how it was before and after body practice, and reflect on the potentiality of group work and groups for health promotion. This is a moment of knowledge sharing, physical activities, relaxation, and joy. In short, it is aimed at the students' appropriation of the way of "making a group" and move in another way, which is "being a group."

[a] *The Raft of the Medusa* questions days without water and food, and only 15 survived. What relationships can be gleaned from the groups? Survivors due to individual characteristics? Willpower, perseverance, and drive versus giving up, weakness, acceptance of one's fate? (...) No! We would say it was based on the inequality of chances, on the conditions that took them out to the sea, on the understanding of these men as merchandise (Brasil, Ministério da Saúde, 2005, p.93)

The population groups can be diverse—children, adolescents, young adults, workers, women of reproductive age, people with chronic diseases, people with back pain, breastfeeding mothers, black people, indigenous people, homeless people, LGBTQIA+ groups, etc. This encounter with population groups generates a demand for more specific knowledge about the needs of people. For example, a group of elderly people expect the students to know the health indicators of their population group, understand the needs of people in this phase of life, and know public policies directed at this group and the challenges described in the scientific literature that make this population group a priority for health promotion actions.

It is at this time that the study on the different approaches and specificities of each group is developed. The training process then takes the next step of putting together the action plan focused on health promotion strategies.

Creating the Action Plan

After the first group activity, in which it was possible to get to know the group and its expectations, the students reflect on what they heard at the meeting. Based on these reflections, the general objective of the action plan becomes more perceptible, making it easier to conceive the structure and content of the experiential workshops that will be proposed to the population group. The staff of the referral service are always invited to participate not only in the workshops, but also in the planning and supervision.

The creation of the action plan and work plans for the workshops is always performed by all the students and subsequently distributed among the different functions, which also makes the group cohesive, allowing everyone to have the vision of the whole. Thus, the action plan also establishes a division of different functions in the group, enabling everyone to experience conducting the activity with the population group, maintain a record on the workshop containing events, discourses, and images that were remarkable, and support the development of the experiential workshop by assisting the participants and/or moderators, if necessary. These functions change at each meeting so that everyone can experience the different aspects and points of view.

The structure of the action plan consists of four items, as illustrated by Fig. 32.2.

The action plan is flexible. The relationships among students, professors, and the population group can bring about changes in the initial plan, as the group promotes awareness among the members in each experiential workshop that enables conceiving of new actions based on the needs that emerge during the workshops.

> *We concluded that the dynamics, in addition to achieving the main objective, promoted reflection on what adolescents feel (...) in a clear way as they analyzed interpersonal relationships for the construction of the instrument. We realized that what we expected from the meeting was far too little for what they brought to it (...)* (Student journal, 2017).

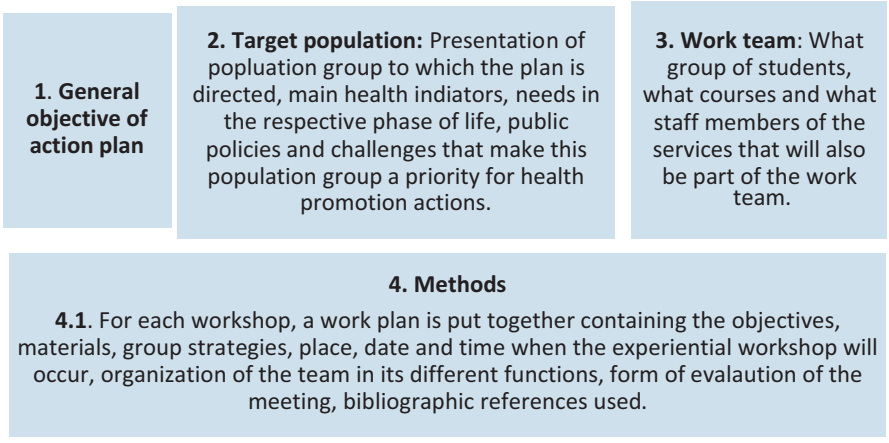

Fig. 32.2 Structure of action plan of Teamwork and Collective Practices module, UNIFESP/BS, Brazil, 2021

Development of Group/Life Workshops and Supervision

The experiential workshops take place at five meetings. Each meeting has a topic that adds to the achievement of the general objective of the action plan, which is health promotion. According to Czeresnia (2003), health promotion involves the strengthening of individual and collective capacity to deal with the multiplicity of health conditioning factors." "[...] this conception of promotion concerns the strengthening of health through the construction of the capacity to choose as well as the use of knowledge with the discernment to pay attention to the differences and singularities of events" (p. 5).

The topics and activities are defined by the students with the support of the faculty members, who facilitate the group construction process by giving voice to the students and space for creativity to emerge in the dialogue and exchanges between them, considering significant aspects of their experiences both within and outside the university. The professors' fundamental objective is for the students to place themselves in the group, establish a dialogue, determine the goal of the action plan, and list the objectives of each experiential workshop, creating activities in which all can participate and/or contribute in everything from planning to the evaluation after the workshop.

As Azevedo et al. (2017) state, referring to the "interprofessional" work:

> Since experience-based learning is one of the pillars of this training, the existence of an interrelationship between theory and practice, the relationship of a common working partnership among the actors in this process and the autonomy of all those involved are brought into the discussion (p. 653).

Thus, the professors' guidance is more focused on organization in order to encourage the fluidity of the meeting, such as planning and organizing the time of the workshops, the reminder that they should put themselves in the another one's place when thinking of activities in order to create proposals that generate interest and stimulate participation, the suggestion that they should try to intersperse busier activities and calmer activities and that all should participate in the activities proposed together with the population group, because only then will everyone be a group, build the group, and give life to it. The supervision activities with the professors take place between workshops. During these activities, the meetings are analyzed, reflections are pointed out through the field journals, and the plan for the next workshop is prepared. Thus, the experiential workshop and supervision are intertwined.

The workshops are permeated with health promotion activities that have the potential to awaken the subjects as a whole in their physical and/or subjective aspects. Proposals are made for activities that awaken cognition, reflection, senses, memories, childhoods, moments of daily life that generate doubts, frustrations, achievements, or conquests, and activities that involve body movement. The meetings are usually ended with activities that promote relaxation.

In the development of the workshops from the planning to the postmeeting evaluation, the students are stimulated to sharpen their vision and refine their sensitivity

during the meetings and in the writing of the journals. Thus, they build understanding and improve possibilities of addressing topics in a more horizontal manner, deconstructing the ideology of competence; experiencing and valuing listening, care and the importance of the knowledge of the other to thus build in the group and with the group new ways of walking through life, of being in the world, with more possibilities of autonomy.

> *It's been a while since the last time I practiced origami and the folds reminded me of other folds, certainly more delirious, but also folds – our own. We can think of them as folds of a fabric, the fabric of life, folds of life. It concerns the strength of the process that is to exist, the curvatures that we make and go through, the metamorphoses, the transformations; how we fold, unfold, fold over from the forces that cross us and affect us, mark us, modify us, embody us, inhabit us, compose us, in short, make us what we are* (Student journal, 2017).

Field Journals: Their Importance and Power in Training

During each workshop, the students keep a field journal that enables the professors and the students themselves to accompany the individual reflexive process on the learning constructed during each meeting and throughout the semester due to its cumulative nature. The journals are presented at two-week intervals, read by the professor, and discussed with the group of students. In the journal, the students discuss experiences during the workshops, situations, and/or theoretical references from the module itself or from other moments in their training that they consider significant for clarification or reflection on the issues presented.

The journals have a pre-established format consisting of (1) a description of the meeting and the activities, (2) reflection on intense aspects that the actions awakened in them, if and how they affected them, and (3) reflections on the integration between the experience and the theoretical training of the seminars.

The journals enable the emergence of doubts, anguishes, discoveries, and pleasures that permeated the meeting as well as daily life in the communities, which is perceived with greater depth at each contact with the situation of the particular space in which life happens. According to Pezzato and L'Abbate (2011, p.1311), for the journal writers to write "about what they lived, they needed to elaborate how a certain action happened, taking it away from the 'natural scene plane' of everyday life, putting it under discussion and on the plane of reflection."

> *(...) the day served as a learning experience for me, because, even though I often felt frustrated, I learned that life is dynamic and that this may happen at many time of my life, and that I will have to learn to deal with it, being a professional who will work in the health field with people and their subjectivities* (Student journal, 2015).

> *(...) it did not escape my mind that I was not very different from the people who were in the group. I realized that my relationship with food (...) was an addiction just like cigarette smoking for them and it was costing me my health too* (Student journal, 2016).

The analysis and discussion of whatever emerges in the journals bring to the dialogue the different perspectives that each student puts into his or her account of the events and the possibility of expanding visions, subjectivities, and reflection on the practice itself and on what was experienced in the act. Thus, the field journal serves as a facilitator of the micropolitical exercise in the act of health training, that is, experience-based training (Abrahão & Merhy, 2014; Bondía, 2002).

Sharing Experiences and "Experience Book"

The finalization of the module is a very special moment in which all classes of students present their experiences with the population groups, describing memories, significant aspects, facilitators, and/or hindrances of the group experience.

This moment of sharing is achieved through the presentation of an Experience Book inspired by a Freinet technique, which is assembled by each group of students together with the population group and staff of the service with whom they had worked. The book is a record of significant memories, learning experiences, poems, drawings, questions, and whatever was considered remarkable about what they experienced in the workshops. The Experience Book is then offered to the population group and can remain as a record of the group at the reference service to which the group is linked, enabling knowledge/recognition of the experience for future moments.

The Experience Book, a set of journals written after each workshop and the action plan, "complement each other and underscore the collective and individual dimensions of the experience" (Azevedo et al., 2017, p. 651). These three teaching tools accompany the journey as a whole and compose the criteria for the evaluations of students in the module.

Analysis of Experience and Health Promotion

This chapter presents the experiences of the Teamwork and Collective Practices module as well as methodological strategies that support the possibility of expanding spaces for listening, dialogue, and reflection through the exercise of group practices aimed at the development of health promotion actions. By building "groupality," the students exercise their ability to plan, program, and implement actions that meet the characteristics and expectations of each group with which they work. The challenges of interprofessional cooperation are the identification of actions that are common to the different fields involved in the training and the requirement of a method that ensures the quality of the experience that occurs during the encounters between the students and population groups.

The aim of such experiences is to underscore the inseparability of teaching, research, and community outreach by offering a powerful space for knowledge

building and know-how produced through interventions that take place in and with groups. Thus, we establish an important commitment between the role of the university and health promotion principles, values, and actions, conferring organicity among these inseparable pillars and health care.

The National Health Promotion Policy addresses the following values and principles: (1) recognize the subjectivity of individuals and collectives in the care process in defense of health and life; (2) consider solidarity, happiness, ethics, respect for diversity, humanization, coresponsibility, justice, and social inclusion as founding values in the process of health promotion; and (3) adopt equity, social participation, autonomy, empowerment, intersectoral collaboration, sustainability, integrality, and territoriality as guiding principles (Portaria de Consolidação N° 2 - Anexo I, 2017).

The connection between the principles of health promotion and the module experience is based on a broad, complex concept of health, closely linked to living conditions, the ability of individuals and groups to take care of themselves, and the exercise of autonomy in the face of adversities imposed by the social, political, and economic context. It starts with the premise that health promotion actions strengthen the exercise of citizenship and access to public policies (Czeresnia, 2003).

Since their origins, the aim of health promotion policies in Brazil is to promote life in its multiple dimensions, involving analyses of the macropolitical (State) and micropolitical (singularity of the subject's autonomy) realms. The National Health Promotion Policy—approved by Ordinance No. 687 MS/GM on March 30, 2008—establishes as a general objective:

> To promote quality of life and reduce vulnerability and health risks related to its determinants and conditioning factors – ways of living, working conditions, housing, environment, education, leisure, culture, access to essential goods and services (Brazil, Ministério da Saúde, 2010a).

It is understood from this objective that health situations are defined by needs identified through analysis and objective procedures but mainly derive from lifestyles chosen by the individual and collective dimensions that configure their daily spaces. This notion is presented at the start of the modules offered by the Health Work Axis, when the direct influence of the social determinants of health is highlighted, along with the defense of equitable, supportive policies, processes, and relationships. Consonant to this discussion, health promotion is presented as a key field of knowledge, concurrent with strategies that aim at ensuring life, overcoming inequalities, effective/affective communication, networking, working in/with groups, collective and solidary practices as well as the defense of a universal healthcare system, such as the *Sistema Único de Saúde* (SUS [Brazilian Unified Health System]).

In consonance with the principles adopted in the Ottawa Charter (1986), the aim is to strengthen the role of individuals and communities in the development of abilities and the power to act for the sake of life itself. From this standpoint, the Health Work Axis is aligned with the guidelines for health promotion, namely, intersectoral collaboration, social and partnership mobilization in the implementation of actions, sustainability, and the public defense of health, all of which are topics addressed in the modules. The theoretical discussions seek to affirm the conception of health as

an experience of life, addressing the possibilities and complexities of this experience and valuing the subjective expression that derives from the health-illness-care process that gives it meaning.

The practical activities and experiential workshops directed at the community in general aim to ensure the social and political commitments of the university with regards to the five fields of action proposed in the Ottawa Charter (1986): implementation of healthy public policies, creation of healthy environments, community empowerment, development of individual and collective skills, and reorientation of health services. The actions developed by the groups of students in the modules operate in the quest for equity, improved quality of life, and the development of care networks. The partnership and involvement of the staff at the services enable strengthening social participation, valuing popular and traditional knowledge, and enhancing individual and collective potentialities of both the staff and participating group.

We believe that group practices enhance the overall well-being of the participants, provoking reflection and possible transformations in the living and working conditions that shape underlying the health problems. The aim is to increase the autonomy and coresponsibility of individuals and groups with regards to integral health care in a constant struggle against situations of inequality of any nature (social, racial, gender, etc.). These are collective practices that seek to value and optimize spaces for coexistence, where the exchanges and sharing of experiences produce mutual forms of affection. Therefore, health promotion actions qualify existence; it is a search for the expansion of the social, existential, and ethical dimensions of life (Czeresnia, 2003).

Therefore, assuming the pillars of health promotion in this educational context implies assuming a conception of method and a worldview that translate into interventions with a particular ethical-political direction and critical nature with regards to the resulting theoretical-practical reflections (Mendes et al., 2016). This perspective is based on the premise that health promotion practices can empower people, who, when strengthened individually and collectively, generate the expansion of autonomy, the promotion of solidarity networks, and the encouragement of social participation. This creates a path from technique to ethics, from passivity to activity, and, especially, from heteronomy to autonomy.

The proposal of the Health Work Axis is developed through the engagement of individuals who give meaning to each experience, in which the participatory process is as important as achieving the expected results, generating renewed meaning for relations, with new discoveries and learning, thereby contributing to the transformation not only of the "other" but also of a given social context in which we all live. The action-reflection-action movement is expressed in this excerpt from a field journal:

> *My development as a human being at that meeting was mainly in the moment of conversation, when I heard criticism and managed it in a constructive way. I felt myself growing in the sense of absorbing the criticism with reflective eyes, with the will to change and see what is best for the situation, without taking it personally. I hope to be able to practice this change in upcoming meetings and continue to keep myself open to constructive criticism* (Student journal, 2017).

We recognize the importance of interprofessional training in which technical–scientific knowledge of the health field is not enough for the effectiveness of a given intervention project. Participation in groups and with groups is fundamental to the action and experience of individuals to be a decisive part of choices in the direction of autonomous life projects. Within the encounter, therefore, lies the enhancement of experience. It is not merely a matter of considering how others "deal" with the diversity of situations in their singularity, but rather of considering what collective practices can produce as elements that generate transformation.

Final Considerations

We believe that the values and principles of health promotion are crucial, useful, and necessary to the development of interprofessional training centered on groupality. In this chapter, we share the method used and the elements that affirm the potential application of this experience in other contexts, whether in the training of future healthcare providers or the development of work with groups and in groups that involve the production of health care, group experiences, interpersonal, interprofessional, and interprofessional relationships and the creation of spaces for the sharing of experiences. Health promotion is a fertile field of strategies for the production of health from the individual to the collective level—a powerful toolbox for values such as solidarity and social participation to be strengthened.

Despite the challenges of interprofessional cooperation, we can say that the Teamwork and Collective Practices module leaves its mark on the students not only when the intervention proposals are developed as planned, but also when it is not possible to carry out the activities as expected, requiring the collective conception, evaluation, and creation of other strategies. Collective practices enable us to understand that working with health promotion means working with processes and relationships among different contexts, histories, and types of knowledge. Nothing is set. Everything is still to be done, procedurally.

Table 32.2 brings our reflection on the six triggering questions suggested by the Editors.

Table 32.2 Authors´ reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	The author's view on Health Promotion considers that this activity is aimed to increase the quality and living possibilities of people, in line with the reduction of situations of social inequalities and health risks.
What is the institutional and political context of your experience (participants, professions and courses involved, duration, and frequency of activities)?	The reported experience has been developed since 2007 in a public Brazilian university and involves approximately 9 professors and 120 students from 5 undergraduate courses—Nutrition, Occupational Therapy, Psychology, Physiotherapy, and Physical Education. The Teamwork module is offered every semester and takes place over 16 weeks. Nine groups, encompassing 10 to 15 students pertaining to the five undergraduate courses, carry out the activities. Each group develops an action plan directed to a specific group, covered by the services provided by the University. Since its inception, this experience has been developed with various population groups—children, teenagers and young people, workers, black people, quilombolas, indigenous people, homeless people, and LGBTQIA+ groups, among others.
Which theories and methodologies are used in the teaching-learning process?	The theoretical perspective is based upon concepts such as group (Casetto, 2013), Health Promotion (Czeresnia, 2003; Ottawa Charter, 1986), experience (Bondía, 2002), and interprofessionality. It assumes the principles of Popular Education (Freire, 2007; Chauí, 2014), valuing popular and traditional lores. It uses a methodological proposal based on the active participation of students and participants of the assisted group, understanding that the experiences are fundamental for the accumulation of knowledge that is necessary to work in and with groups. The teaching-learning process is anchored in the concept of Health Promotion relating health to the social determination of living conditions, highlighting collective participation and individual skills as essential factors for building a healthy life (Czeresnia and Freitas, 2003).
What forms of assessment are applied, results achieved, and challenges faced?	The evaluations refer to the processes of building, participation, and conduction of the activities proposed in the action plan, elaborated based on the demands of each group. The records in the Field Diaries are also evaluated, which must be composed of description of the meeting and the activities, reflection on intensive aspects, and reflection on the experience and theoretical training. To the population group, the results are shared in the Book of Experience, and express the memories and significant learning about what they experienced in the workshops, to allow knowing/recognizing the experience in future moments. The challenges are related to the proposal of an interprofessional training in which the technical–scientific knowledge in the field of Health Promotion is built from experience and participation in working in and with groups.

(continued)

Table 32.2 (continued)

Questions	Take-home messages
Which principles, pillars, competencies, or approaches to Health Promotion do you base your plan of teaching and learning?	The principles of Health Promotion, that are the basis of the experience of the module, have foundations on a broad and complex concept of health, closely linked to living conditions, to the ability of individuals and groups to take care of themselves, and to the exercise of autonomy in the face of adversities imposed by the social, political, and economic context. It is aligned to the pillars of Health Promotion by producing knowledge and strategies aimed at guaranteeing life, overcoming inequalities, effective and affective communication, networking and working with groups, collective and solidary practices, and the defense of a universal health system, such as the SUS. In line with the principles adopted in the Ottawa Charter (1986), the aim is to enhance people and communities' leading role in the development of skills and power to act for the benefit of their own life.
What others could learn with your experience? What is localized and what is "generalizable"?	In this text, we share the methods and the elements that affirm the potential applicability of this experience in other contexts, whether in the training of future health professionals, or in the development of work with groups and in groups. In our experience, we evidenced the possibility of developing the proposal with different population groups—children, adolescents and young people, workers, black people, quilombolas, indigenous people, street dwellers, and LGBTQIA+ groups, among others. However, we understand that the generalization of this experience is only possible assuming that the starting point is anchored on the knowledge of the territory and the living conditions in which people live, and if it is directed to offering health promotion actions that respond to their demands.

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Part V
Health Promotion Assessment and Quality Assurance

Chapter 33
Introduction to Part V: Health Promotion Assessment and Quality Assurance

Shu-Ti Chiou and Marco Akerman

Health promotion emerged as a distinct discipline in the late 1980s. Education and training of a competent workforce with the necessary knowledge and skills to develop, implement, and evaluate health promotion policies and practice is crucial to mainstream and sustain global health promotion action. Since then, worldwide efforts flourished, such as those in Australia, New Zealand, Canada, USA and Europe, to identify a set of core competencies to serve as the foundation for designing contemporary professional training for health promoters.

The International Union for Health Promotion and Education (IUHPE), a global professional association with long-term official relationship with WHO and having members from all six regions including the above-mentioned countries and regions, has prioritised workforce development for health promotion at local, national, regional and global levels in its previous and current strategic plans, and identified 'Capacity building, education and training' as the focus of one of its global vice presidents. In 2008, the IUHPE as a key actor together with the Society for Public Health Education (SOPHE) convened the Galway Consensus Conference and produced a draft of competency-based framework for health promotion in 2009. This developed into the 'CompHP Project' funded by the European Union, with the IUHPE as a core project partner. In 2012, the resulting CompHP Accreditation Framework was piloted and operationalised as the European Health Promotion Accreditation System from 2013 to 2016. In 2016, in response to proposals from other IUHPE regions, this competency-based quality assurance system was

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expanded to the global level and was formally launched as the IUHPE Health Promotion Accreditation System at the 22nd IUHPE World Conference.

This session is composed of three chapters to present experiences and insights from these milestones on the path towards quality assurance for health promotion teaching and learning.

In Chap. 35 on '*Core competencies for health promotion: development and experience in pedagogy*', Battel-Kirk and Sendall introduced the IUHPE Core Competencies for Health Promotion (referred to as 'the competencies') and the associated Professional Standards which form the basis for quality assurance in education and training for health promotion practitioners and others whose role includes health promotion. The authors provided details on the consensus-building process and the resulting eleven competency domains. In addition, findings from the international literature on the use and impact of the competencies in health promotion pedagogy are presented. Feedbacks from health promotion educators are discussed with reference to learning and teaching strategies and assessment. It was shown that the IUHPE Competencies are useful both in courses specific for health promoters and in education and training for persons from other disciplines with a health promotion role. They are also helpful in developing interdisciplinary education and partnerships with other sectors. Implementing the competencies had a positive impact in health promotion education by contributing to quality assurance, consistency in teaching and learning, and marketing of education and training to students and other stakeholders. Health promotion educators have a role to play in raising awareness and promoting the use of the competencies for quality assurance in teaching and learning.

In Chap. 34 on '*The IUHPE Health Promotion Accreditation System – development and experiences of implementation*', Battel-Kirk and Sendall, together with the IUHPE Health Promotion Accreditation Action Group, provide further details of the IUHPE Health Promotion Accreditation System (referred to as 'the System') on its development, operation and feedbacks from the users.

Aiming to promote quality assurance and competencies in health promotion practices, education and training globally, the System is premised on international consensus that health promotion practitioners require specific education and Continuing Professional Development (CPD) to attain and maintain discipline-specific knowledge and skills to ensure quality in health promotion practice. The application processes for courses and practitioners are both provided. Experiences and feedback from users of course accreditation are analysed and shared, with suggestions for future applicants. As for the registration of practitioners, competency requirements for registration and CPD requirements for re-registration are presented, and the services of the existing national accreditation organisations, which have a key role on practitioner support, are provided. Finally, the authors discussed the future of the System in the context of the global sustainable development movement.

Brick by Brick, Chap. 36, discusses '*building a house of health promotion on a foundation of political science theory*' to help political science students to tackle health issues. Would it be a new challenge for discussing competencies?

This section is helpful in supporting course organisers to make the best use of IUHPE's core competencies framework in their course design, to prepare for the (re-)accreditation and to learn the examples of best practices in competencies-based health promotion teaching.

In conclusion, as health promotion is playing a more significant role than ever in the world's sustainable development journey towards 'leaving no one behind' which sets out explicit targets and measurable outcomes for all governments and requires a health-in-all-policies approach to arrive at those targets, quality assurance of workforce development that helps equip health promotion professionals with the needed competencies to mobilise scaled changes with more predictable performances will continue to mainstream health promotion education and training in the future.

Chapter 34
The IUHPE Health Promotion Accreditation System: Development and Experiences of Implementation

Barbara Battel-Kirk and Marguerite C. Sendall

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Developing the System

The development of the System was driven by recognition that, while quality assurance and professional recognition for practice, education, and training had been identified within health and other professional fields, few were available in health promotion. Research indicated that the health promotion workforce was at different stages of development within and across countries, with varying levels of professional identity, education, and career development evident (Battel-Kirk et al., 2009; Dempsey et al., 2011a). The System responds to the need for a quality assurance system to unify and strengthen the diverse health promotion workforce by providing formal competency-based professional recognition of practitioners and courses.

The development of the System comprised three stages (Fig. 34.1).

The CompHP Accreditation Framework

The CompHP Project (Barry et al., 2012) developed competency-based standards and an accreditation system for health promotion practice, education, and training as a means of developing and strengthening health promotion workforce capacity. The Project produced three frameworks[1]:

- The CompHP Core Competencies for Health Promotion Framework (Dempsey et al., 2011b)

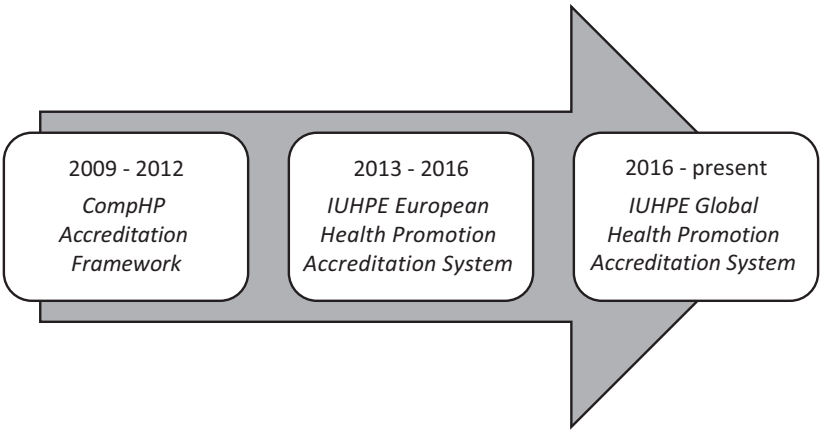

Fig. 34.1 Stages in the development of the IUHPE Health Promotion Accreditation System

[1] *The CompHP Core Competencies and CompHP Professional Standards were renamed as the IUHPE Core Competencies and Professional Standards in 2016 https://www.iuhpe.org/images/JC-Accreditation/Core_Competencies_Standards_linkE.pdf*

- The CompHP Professional Standards for Health Promotion Framework (Speller et al., 2012)
- The CompHP Health Promotion Accreditation Framework (Zander, van der, et al., 2012)

The development of the CompHP Accreditation Framework drew on several sources, including reviews of international competency-based approaches (Battel-Kirk et al., 2009; Dempsey et al., 2011a). The development process was informed by the Galway Consensus Conference Statement (Allegrante et al., 2009; Barry et al., 2009; International Union for Health Promotion and Education (IUHPE), 2009), which highlighted the need to develop competency-based quality assurance systems globally. The CompHP Core Competencies (Dempsey et al., 2011b) and Professional Standards (Speller et al., 2012) formed the assessment criteria for the accreditation framework. A multiple-method approach was used to develop consensus on the accreditation framework among key stakeholders in the European health promotion community (Battel-Kirk et al., 2012; Zanden, Van der, et al., 2012). This approach included an online survey, focus groups, and web-based consultations. The draft framework was tested in academic settings to ascertain its relevance to health promotion education and to evaluate course accreditation processes and application forms (Contu et al., 2012). The draft framework was also tested in practice settings to explore its usefulness and acceptability in countries with differing levels of health promotion capacity, mainly in relation to practitioner registration (Gallardo et al., 2012).

Each stage of the development process was reviewed by the 24 European project partners drawn from the health promotion policy, practice and academic sectors and an international advisory group of experts with experience of competency-based approaches to health promotion at a global level. The development of the accreditation framework, while focused in the European region, thus drew on, and added to, the knowledge base and experience of developing competency-based quality assurance in health promotion globally (Barry et al., 2012).

Findings from the consultations informed the structures and processes of the current System. For example, Contu et al. (2012) found that many health promotion-focused courses had differing titles, including some that did not use the term ‘health promotion’. These findings establish that eligibility for accreditation within the System should be based on course content, rather than course title. Feedback from the practice setting (Gallardo et al., 2012) led to the provision of a time-limited opportunity for experienced health promotion practitioners who do not meet the agreed educational criteria (undergraduate or postgraduate status) to apply for registration to ensure that their wealth of experience was not lost. Findings from the consultations in both settings confirmed that levels of health promotion capacity vary and that some countries may not have the resources or infrastructure required to develop and maintain an accreditation process (Battel-Kirk et al., 2009; Dempsey et al. 2011a). For these countries, it was agreed that the CompHP Core Competencies Framework could be used as stand-alone document, or in conjunction with the CompHP Professional Standards, as the basis for quality assurance for health promotion practice, education, and training (Barry et al., 2012; Dempsey et al., 2011b, c).

The IUHPE European Health Promotion Accreditation System

The CompHP Accreditation Framework was published in 2012 and piloted in 2013. A governance structure and agreed policies and procedures were established, and a web-based application system was developed and tested. The resulting refined framework was operationalised as the European Health Promotion Accreditation System from 2013 to 2016 (Battel-Kirk & Barry, 2013; Battel-Kirk et al., 2015).

The IUHPE Global Health Promotion Accreditation System (https://www.iuhpe.org/index.php/en/the-accreditation-system)

In 2016, in response to proposals from other IUHPE regions, the European system was expanded to the global level. The System was formally launched as the IUHPE Health Promotion Accreditation System at the 22nd IUHPE World Conference in Curitiba, Brazil, in May 2016. To highlight this development, the 'CompHP' Core Competencies and Professional Standards were renamed the 'IUHPE' Health Promotion Core Competencies and Professional Standards.

Implementing the System[2]

Goal of the System

The goal of the IUHPE Health Promotion Accreditation System (referred to as 'the System') is to promote quality assurance and competence in health promotion practice, education and training globally. The System provides professional recognition of practitioners and educational courses that meet agreed criteria. The System is designed to be flexible and sensitive to different contexts while maintaining robust and validated criteria.

The core concepts and principles of health promotion as defined in the Ottawa Charter (World Health Organization (WHO), 1986) and successive WHO charters and declarations on health promotion (WHO, 1991, 1997, 2000, 2005, 2009) underpin all aspects of the System. Health promotion is defined as *'the process of enabling people to increase control over, and to improve, their* health' (WHO, 1986) and as 'a *comprehensive social and political process which embraces action directed at strengthening the skills and capabilities of individuals and actions directed toward changing social, environmental and economic conditions which impact on health'* (Nutbeam, 1998). Ethical values and principles, including equity and social justice,

[2] *For details on all aspects of how the System works and application and assessment processes, please see https://www.iuhpe.org/index.php/en/the-accreditation-system.*

respect for autonomy, and collaborative and consultative ways of working underpin the System (Dempsey et al., 2011b).

Terms Used in the System

Accreditation is the process of evaluating education and training courses to determine whether they meet agreed criteria based on the IUHPE Core Competencies and Professional Standards. Practitioners graduating from an accredited course are automatically eligible to apply for registration, with proof of graduation the only requirement.

Registration is the confirmation that an individual is fit to practise health promotion at entry level,[3] based on their educational attainment, competence and/or work experience, CPD, or any agreed combinations of these.

Operation of the System

Since 2016, the System has been implemented globally. Currently, there are practitioners registered within the System in Australia, Ireland, Israel, Italy, Nigeria, and the United Kingdom and accredited courses in Australia, Estonia, Finland, Ireland, Italy, Portugal, the Netherlands, and the United Kingdom. Applications for course accreditation currently in progress indicate a broader global interest. However, there are challenges to the expansion of the System, in particular limited resources. Recent research has also highlighted language and translation issues as challenges in implementing competency-based approaches, with differences in cultural and linguistic interpretations of key concepts and core words associated with health promotion and competency (Battel-Kirk & Barry, 2019a, b).

Research indicates that targeted marketing strategies are needed to secure 'buy in' for the System from key stakeholders, including policymakers, academic institutions and employers, a critical component in progressing its implementation globally (Battel-Kirk & Barry, 2019a, b).

These and other challenges that may arise as the System expands, require understanding of the relevant political, social, cultural, professional and educational contexts within which health promotion is operationalised (Battel-Kirk & Barry, 2019a, b).

[3] '*entry-level' refers to roles that are normally designed or designated for recent graduates of a discipline and typically do not require prior experience in the field.*

Benefits of the System

In addition to providing formal recognition for practitioners and courses, the System is designed to provide:

- Clear, agreed guidelines and quality standards for the health promotion knowledge, skills and values required for effective and ethical practice
- A basis for quality assurance in health promotion practice, education and training
- Accountability to the public through the registration of health promotion practitioners
- Assurance that accredited health promotion courses provide graduates with the knowledge and skills required for effective practice and that awards are validated based on agreed criteria
- Facilitation of movement of employment through agreed registration procedures
- A reference point for employers in recruitment and selection of health promotion practitioners
- Greater recognition and visibility of health promotion and the work done by health promotion practitioners

How the System Works

The System comprises a devolved model involving National Accreditation Organisations (NAOs) that are approved by the IUHPE Global Accreditation Organisation (GAO) to register practitioners within their catchment area. The National and Global Accreditation Organisations have specific functions and tasks (Fig. 34.2) while using the same agreed criteria, policies and processes. Once an NAO is established in a country all applications for registration from that country are processed by the NAO. In countries where no NAO exists, practitioners can apply to the GAO for registration. The accreditation of courses, irrespective of location, is managed by the GAO.

Course Accreditation

Applying for Course Accreditation

Accreditation is available only for complete educational programmes/courses at either undergraduate or postgraduate level that:

- Cover *ALL* domains of the IUHPE Core Competencies and Professional Standards

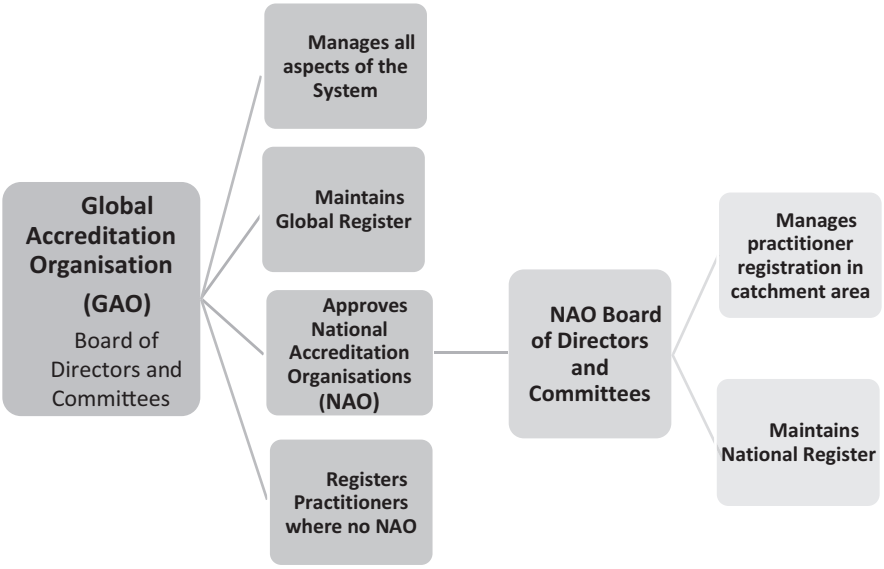

Fig. 34.2 How the IUHPE Health Promotion System works

- Demonstrate how their aims, ethical framework, and content relate to the IUHPE competency domains
- Demonstrate how they prepare graduates to be competent health promotion practitioners as defined in the System

As the System is premised on voluntary accreditation, rather than statutory regulation, it focuses only on ensuring that graduates meet the agreed criteria for health promotion professional competence. Course providers applying for accreditation must therefore demonstrate that they are formally recognised as accredited providers of education at undergraduate or postgraduate levels in their country or region.

Course providers apply online to the GAO Assessment Committee for accreditation. The application comprises the submission of a completed application form, course materials considered relevant to the application (e.g. course handbooks, websites) and payment of the required fee(s). The major elements of the application form consist of a short summary of how the course meets the required criteria and a detailed self-assessment process. The self-assessment process involves a mapping process to demonstrate how the course content covers each domain of the IUHPE Core Competencies and Professional Standards.

Assessment and Outcome of Course Accreditation

When the completed application and administrative fee are received by the GAO, the application is assessed by two independent assessors. All assessors undertaking assessment of courses have a minimum of two years' experience in health promotion practice and two years' experience in an academic setting. If both assessors do not agree on the eligibility of the course, the Chair of the Assessment Committee can act as a third assessor or refer the application to the Assessment Committee. The possible outcomes from the assessment process are detailed in Fig. 34.3.

Course accreditation is valid for a five-year period after which the full application process must be repeated when applying for reaccreditation. Accreditation of a course can be revoked or cancelled for several reasons including breach of the System's ethical principles, dishonesty in the application process and failure to pay fees. All decisions on accreditation can be appealed to an Independent Appeals Committee by submitting a letter outlining the reasons to the GAO.

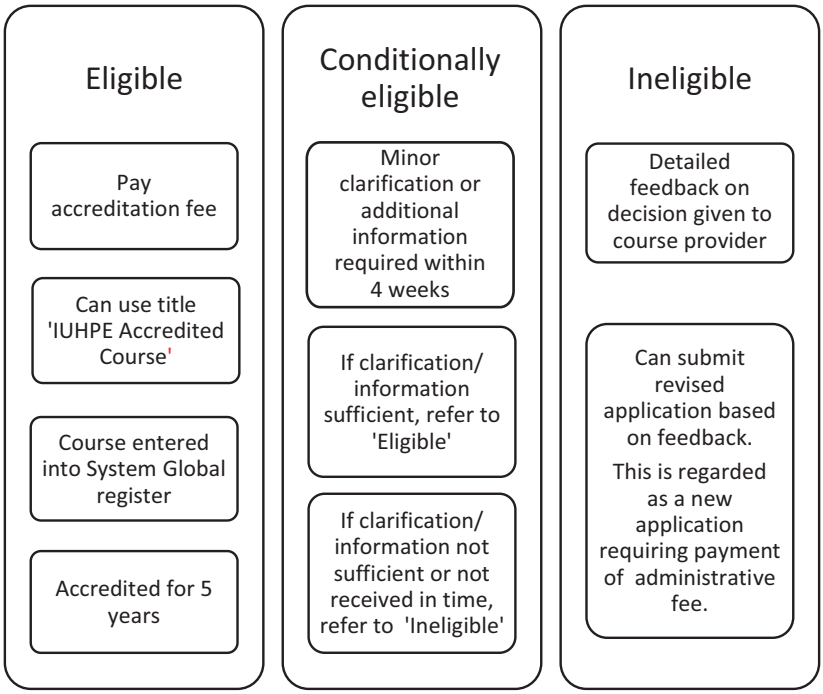

Fig. 34.3 Possible outcomes in the assessment process for course accreditation

Experiences of Accreditation and Opinions on its Benefits

The information presented in this section draws on analysis of data from two main sources:

- Feedback from leaders of IUHPE accredited courses who were contacted by the authors via email in March 2021 and asked to share their experiences of using the System. A total of eight course leaders responded and their responses were analysed using systematic analysis (for more information on this analytical process see Battel-Kirk & Barry, 2019b). Direct quotes from those who have used the System are provided to give insight into each theme identified.
- Unpublished data collected and collated in a PhD study (Battel-Kirk, 2020) that used a two-phased mixed-methods design informed by findings of a scoping review of the literature (Battel-Kirk & Barry, 2019c). The study included an online survey of those involved in the original consultations undertaken in developing the CompHP Competencies, augmented by snowball sampling across the wider European health promotion community. A qualitative case study focusing on the implementation of the competencies in two embedded units of analysis (Ireland and Italy) was also undertaken (Battel-Kirk & Barry, 2019b). The initial case study sample comprised five national experts from each country who were knowledgeable about the practice context of health promotion, including leading members of national health promotion professional and academic bodies and others in health promotion/public health departments and statutory/non-governmental organisations with a remit for health at country level. These experts acted as key informants and members of a National Reference Group in their country and assisted in identifying additional key informants to be interviewed in their country. A total of 13 interviews were completed in each country. Recordings of the interviews were transcribed and the data was analysed using thematic analysis. Quotes from informants in their own words were included to 'tell the story' and underpin the themes with examples of real-life experiences.

Managing the Application Process

Seven key themes regarding the management of the application process for course accreditation emerged from this data (Fig. 34.4).

Dedicate time All course leaders made reference to the need to dedicate sufficient time when completing the application process. One leader referred to the process as '*time intense',* another as considered it *'time-consuming',* while another recommended that applicants:

> *'Be mindful of timeframes required to prepare the application and receive feedback in line with individual university governance structures and requirements'.*

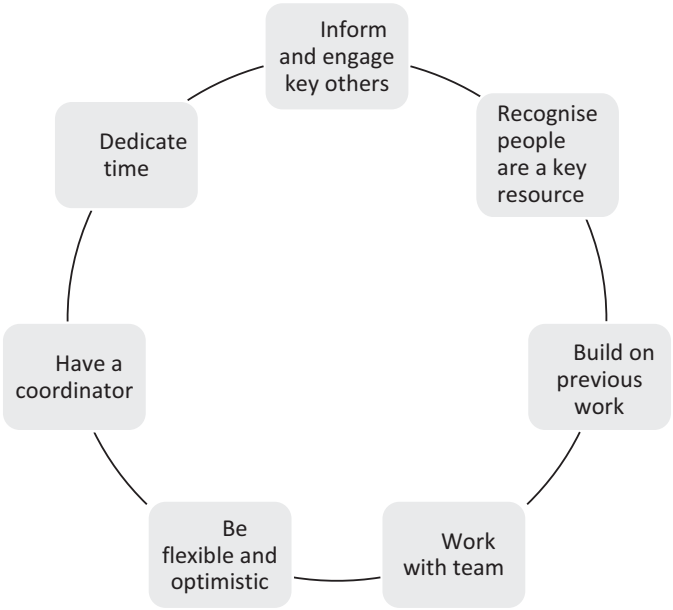

Fig. 34.4 Seven themes representing experiences of managing the application process

Recognise that People Are a Key Resource People, rather than material resources, were identified as the key resource required in the accreditation process.

> *We didn't need any particular kind of resources…our work was mainly to think in another way …to change…not our vision as what we have more or less the same vision as the competencies… but how they were covered in the course.*

The importance of staff support was highlighted by another course leader:

> *There was good will within the programme staff. They offered their modules (for mapping) and spent the time going through them…that was the big resource.*

Involve and Engage Key Others The importance of engaging and getting 'buy-in' from management, the academic team and, in some universities other departments and stakeholders, was frequently noted in relation to managing the accreditation process, for example:

> *One of our first steps was to inform a wider group of people about accreditation…not just the team people within our department…I think that was important …not just the 2 or 3 of us doing it… getting understanding and buy-in from everyone else… it was important that everyone else know what was required.*

In one university, presentations on the health promotion programme and accreditation were used to engage stakeholders from other courses and disciplines:

We organised a seminar presentation at the beginning of the course in different years involving the directors of the schools…nursing and different graduate courses…the directors and deans. They all say it is important to have this framework of competencies supporting the courses.

Work with a Team There was a strong emphasis on the importance of a using a team approach to the application process, for example:

Future applicants should have a team approach to the application rather than having an individual working in isolation.

Have a Coordinator The importance of having a coordinator was stressed with a suggestion that this should be a dedicated role:

Consider employing someone in the role of 'specialised accreditation support officer'…to check and collate information and supporting evidence, deal with the finer points of the application and provide extensive gap analysis and editing.

Build on Previous Work on the Course Building on what was already known and accepted within a course was viewed as a positive way to encourage support and commitment to the accreditation process, for example:

This (application process) was a moment…a point of strong reflection … in which we are moving from the past in some way… it's not completely new… but it was important because it was a structured system.

Be Flexible and Optimistic Some challenges identified in applying for accreditation were viewed as potential learning opportunities if a flexible approach was adopted. In one instance, the overlap in the performance criteria in the IUHPE Professional Standards was found challenging in mapping the course, in particular when working with lecturers who were not from a health promotion background. However, a positive outcome was reported as the situation, as it:

Prompted meetings with all lecturers and the discussion on the overlap gave lecturers from other disciplines… (particularly new lecturers)… a better understanding of health promotion competencies and their relevance to their specific module.

One course leader reported that while they found the accreditation process '*quite a challenge*' they considered that '*some struggle is normal or even necessary'* in accomplishing the goal of accreditation. Another stated that:

(the department) do not view the process as a barrier, but more as core business.

An example of how possible confusion in the application process was prevented in one university was also detailed:

We held workshop days where we went through each module with each module leader and 'walked' them through each module to see if they were reaching the required competency. I think this is necessary so there is no confusion or misinterpretation of the competencies and that the application is thorough and consistent.

Viewing the application process as an ongoing endeavour was also suggested:

> *The process follows a pattern of engagement, mapping, reflection and review. In terms of developing the course overall…mapping where the competencies are delivered (in updated courses) is an ongoing process.*

Overall, the application process in itself, in addition to achieving accreditation was described as *'worthwhile', 'prompting reflection' and 'thought provoking'*.

Benefits Attributed to Accreditation

Five key themes emerged from feedback on the benefits attributed to course accreditation (Fig. 34.5).

Assures Quality by Improving Course Structure and Content The main benefit of accreditation reported was that of assuring quality by improving course structure and content. For example, one course leader emphasised how course accreditation helped review and improve their course:

> *From an academic/lecturer perspective, accreditation has helped us understand or translate what we are actually doing in terms of delivering content and designing assessments in relation to the IUHPE competencies in a more concrete way. For example, the competencies are embedded in self-reflection tasks and assessments to be completed by students, and as such, has strengthened our course content.*

Supports Marketing of the Course to Students and Other Stakeholders There were many reports indicating that having IUHPE accreditation was of benefit when marketing courses to prospective students and other stakeholders, including employers, for example:

> *It (accreditation) is … very useful and relevant… in particular to me as a course leader in representing the course to prospective employers.*

Accreditation was linked to maintaining a competitive edge in one instance:

> *The main drivers to apply for accreditation of the health promotion course revolved around maintaining our competitive advantage. Accreditation with IUHPE means the course remains competitive and relevant.*

Benefits Students' Learning and Professional Prospects Feedback indicated linked benefits in relation to marketing and students' learning:

> *Absolutely it's a benefit to us when we are marketing the course and it's also a benefit to the students … that this is a relevant course that has been accredited recently and is up for reaccreditation and they are getting those skills. So, it's positive for them.*

Other feedback focused on the benefits of accreditation in relation to students' learning and professional prospects. It was reported that students valued course

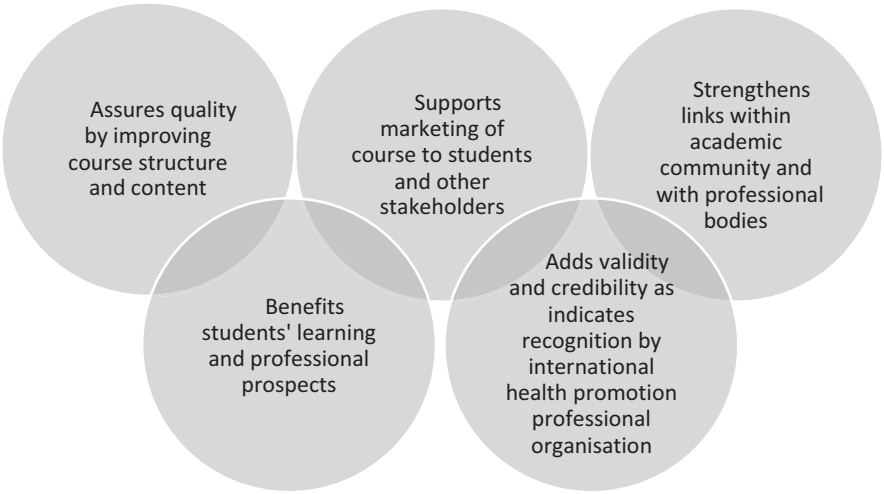

Fig. 34.5 Benefits attributed to course accreditation

accreditation because they could apply for registered health promotion practitioner status, adding credibility to their academic qualification:

> *We are telling them (students) that this is an accredited programme so that you can apply for registration and if you go to Australia, it is recognised there too which is a nice plus for them to hear… that it is recognised across the world.*

Adds Validity and Credibility to Courses as Indicates Recognition by an International Health Promotion Professional Body Overwhelmingly, course accreditation was supported because it added credibility to courses by benchmarking them to established and recognised international core competencies. Some leaders suggested that recognition by an established international professional organisation provided validation that the course was grounded in established health promotion theory and practice, for example:

> *Within the university it is first important for the profession to show that the course is not something that you are organising alone but (that it) has international recognition. So, at a professional level (we) needed to show that they are not something strange but that they are working with something that other countries officially recognise and also to explain better what you are offering.*

Strengthens Links within Academic Communities and Professional Bodies Feedback indicated that accreditation can strengthen links between academic institutions and health promotion professional organisations. Having a course accredited within the System was also reported as raising students' awareness of the IUHPE and other professional groups (e.g. the AHPI[4]), for example:

[4] *Association of Health Promotion Ireland - https://ahpi.ie/*

> *The process has strengthened links between our Institute and the IUHPE and made lecturers and students more aware (of them) and likely to connect with their activities.*

The role of accreditation in strengthening links across the health promotion education sector was also noted*:*

> *We are members of an Australia-wide health promotion teaching and learning community of practice, where one of the themes for discussion is IUHPE accreditation. Having that common denominator facilitates knowledge sharing and experiences and allows us to develop partnerships with other health promotion education providers, strengthening the professionalisation of the industry as a legitimate standalone sector.*

One quote encapsulates the enthusiasm shared by many course leaders in relation to accreditation, and their advice to others considering an application:

> *I would say go for it…If it is another educational institution in the same situation (as our course) I would say we found it very, very, useful.*

Evidence of the Use and Impact of the IUHPE Core Competencies in the Context of Accreditation

In recent research, health promotion education was rated as the area with the highest use of the competencies and highest expected future use. The highest current and expected impact of the competencies, and evidence of their impact, was also reported in the health promotion education context (Battel-Kirk & Barry, 2019a). These findings suggest that the competency-based approaches, such as those used in the System, have the potential for long-term positive impact on health promotion as they inform students' future practice.

Practitioner Registration

Practitioner Registration

The minimum standard of professional education required to apply for practitioner registration within the System is undergraduate level. Graduates of courses accredited within the System are eligible for registration on proof of graduation, with no further requirements. Graduates of health promotion courses that are not accredited within the System or graduates of courses in agreed related disciplines[5] are eligible if they have a minimum of two years' experience in health promotion practice (as

[5] *Including public health, health education, and social sciences including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, and political science. Other academic qualifications may also be deemed appropriate, but must be approved by GAO Board of Directors.*

defined in the System) in the preceding five years. When applying, these practitioners must complete a self-assessment of competence based on the IUHPE Core Competencies and Professional Standards. A time-limited application option is available for practitioners who do not meet the educational criteria. These applicants must have a minimum of three years' experience in health promotion practice in the preceding five years and complete a self-assessment of competence.

Practitioner Re-registration

Practitioners are required to re-register every three years. Re-registration is usually managed by the relevant NAO but, where no NAO exists, application can be made to the Global Accreditation Organisation (GAO). Requirements for re-registration within the System are that the practitioner is:

- Registered within the System
- An active practitioner with a minimum of one and a half years of work experience in health promotion practice in the preceding three years
- Is able to show they have participated in a minimum of 75 hours across a diversity of CPD activities in the preceding three-year period.

Continuing Professional Development

Acquiring a competency is viewed as an ongoing process within the System (Dempsey et al., 2011b). CPD is defined as '*study designed to upgrade the knowledge and skills of practitioners in the profession after initial training or registration'*. CPD is recognised as involving any activity where the individual is learning and can incorporate a range of formal, informal and work-based activities. CPD within the System is aligned to enhancing the professional status of practitioners, promoting research and evidence-based practice and providing stakeholders with evidence of the profession's commitment to high quality practice.

CPD benefits practitioners by promoting and maintaining competence to practice, providing structure and support for practice, improving confidence, increasing job satisfaction and enhancing lifelong learning and career opportunities. Organisations also benefit from CPD as it contributes to quality assurance, helps to meet organisational objectives, contributes to meeting demands for accountability and improves inter-professional working, staff motivation and morale.

The CPD process related to re-registration requires that the practitioner reflect on and assess their knowledge, skills, and competence in the context of the IUHPE Core Competencies and Professional Standards in relation to their current and potential future role.

The IUHPE Accreditation System uses a credit points system to record CPD activities where one credit equals one hour of participation in a CPD activity. Given the diversity of contexts and settings within which registered practitioners practice globally, CPD requirements are based on a range of recognised activities (Table 34.1) rather than being limited to formally 'accredited' learning opportunities. Activities other than those listed may be accepted, but these must be justified as relevant to the System's criteria and approved by the GAO.

The practitioner is only required to submit outline details of the hours of engagement in specific CPD activities in the re-registration process. However, proof of completion of CPD activities (e.g. records of attendance at conferences, meeting, and details of awards) must be kept as evidence and may be requested at any time as part of the System's quality assurance processes.

At the global level, information on educational and professional CPD opportunities offered by the IUHPE and other health promotion organisations is shared on the IUHPE website (https://www.iuhpe.org/index.php/en/), These opportunities include IUHPE global and regional health promotion conferences, often offering virtual attendance, and webinars on current health promotion topics.

The NAOs active in Australia and Ireland provide regularly updated information on CPD opportunities on their websites:

Australia: https://www.healthpromotion.org.au
Ireland: https://ahpi.ie

Both NAOs have taken a strategic approach to CPD for re-registration. Building partnerships with key stakeholders – for example, academic institutions – is

Table 34.1 CPD activities recognised by the IUHPE Health Promotion Accreditation System

Activity	Description
Course	Participating in education to increase knowledge/skills in health promotion.
Training	Participating in activities leading to skilled behaviour.
Conference	Participating in a conference focusing on health promotion.
Meeting	Participating in formally arranged meetings with the purpose of sharing experiences/learning on health promotion.
Workshop	Participating in group learning on health promotion.
Lecture	Giving a formal presentation on a health promotion topic.
Presentation/ Poster	Making a formal presentation on health promotion at a conference or other formal event.
Peer Group	Participating in a group comprising health promotion professionals to share experiences and provide peer support.
Mentored practice	Gaining knowledge and/or skills through working with a health promotion mentor.
Publishing	Publishing an article, book chapter, or book focusing on a health promotion topic.
Professional Activities	Being active in a national or international health promotion professional association/organisation.

recognised by both NAOs as a good use of limited resources when developing CPD opportunities.

In Australia, the NAO provides each registered practitioner with a 'CPD tracker' spreadsheet to help categorise their CPD activities over a three-year period. The completed tracker is then uploaded online as evidence in the re-registration process.

In Ireland, the NAO established a CPD Subgroup whose work is supported by academic institutions, the Health Service and some non-governmental organisations. In 2018, the subgroup surveyed 21 organisations (statutory, academic, NGOs and others) to assess the range and availability of training and education programmes related to the System that are available in Ireland. Using the survey results, the Subgroup built a new 'CPD Opportunities' page on their website detailing all the identified activities. The page incorporates a search function that allows practitioners to look for CPD opportunities related to a specific health promotion competency domain. This section on the AHPI website forms a central hub for information on training, education and CPD for health promotion in Ireland. The Irish NAO also developed a CPD Portfolio document and spreadsheet to support practitioners in collating information on their CPD activities and reflection on learning and learning outcomes.

Health promotion education providers can share information on relevant CPD opportunities by contacting the coordinators of the IUHPE System at global or national level.

Conclusion

The IUHPE Health Promotion Accreditation System provides a competency-based platform for quality assurance in practice, education and training. Research demonstrates that the System contributes to workforce capacity development mainly through its positive impact on health promotion education and training.

While much has been achieved in developing and implementing the System to date, the future presents both challenges and opportunities. The main challenge to the expansion of the System is limited resources. Issues of language and translation pose challenges both in terms of resourcing and the differences in cultural and linguistic interpretations of key concepts and core words associated with health promotion and competency-based approaches. Opportunities to further develop the System are evidenced by applications for course accreditation from a widening geographic spread, the uptake of practitioner registration and continued interest and support from the international health promotion community. Targeted marketing strategies are required to continue the uptake of the System and to promote 'buy-in' from key stakeholders, including employers, to sustain its expansion.

Ongoing emphasis on quality assurance and professional accountability, in particular in the field of education, suggests that the System reflects current thinking about professional education, including the need for formal recognition of quality based on agreed criteria. Competency-based quality assured health promotion

education and training, as recognised in the IUHPE Health Promotion Accreditation System, is a key to developing and maintaining a competent health promotion workforce globally.

Table 34.2 brings our reflection on the six triggering questions suggested by the editors.

Table 34.2 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	The System builds on the core concepts and principles of health promotion outlined in the Ottawa Charter and successive WHO charters and declarations on health promotion. Health promotion is viewed as a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also actions directed towards changing social, environmental, and economic conditions which impact on health.
What is the institutional and political context of your experience (participants, professions and courses involved, duration, and frequency of activities)?	The importance of the understanding sociopolitical context and levels of Health Promotion capacity in relation to the development and implementation identified in recent research is discussed. Content includes reference to the relevant literature at global level, and input from Health Promotion leaders of accredited courses, together with examples of and information on Continuing Professional development and training.
Which theories and methodologies are used in the teaching-learning process?	The focus of the chapter is on the quality assurance aspects of the core content of teaching and learning based on internationally agreed core competencies.
What forms of assessment are applied, results achieved, and challenges faced?	The process of assessment of eligibility for recognition of course accreditation within the System, including the submission of a self- assessment questionnaire demonstrates how applicant courses met the agreed competency-based criteria and the assessment of their eligibility based on analysis of the submitted information is detailed.
Which principles, pillars, competencies, or approaches to Health Promotion do you base your plan of teaching and learning?	The chapter is centred on competency-based accreditation as the basis for quality assurance and professional recognition of eligible Health Promotion education at a global level.
What others could learn with your experience? What is localised and what is 'generalisable'?	The System is open to applications from courses that are complete educational programmes at undergraduate or postgraduate level, cover ALL domains of the IUHPE Core Competencies Framework, demonstrate how their learning outcomes relate to the performance criteria defined in the IUHPE Professional Standards and prepare graduates to be competent Health Promotion Practitioners as defined in the System. The chapter is therefore mainly 'localised' to courses which meet, or aspire to meet the eligibility criteria defined, but may prove useful to a more general audience in terms of awareness of quality assurance in Health Promotion specific courses. The section on CPD has wider, generalisable potential beyond the scope of the System for all with an interest in continuing education and training to support quality in health promotion practice.

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Chapter 35
Core Competencies for Health Promotion: Development and Experience in Pedagogy

Barbara Battel-Kirk and Marguerite C. Sendall

Contents

Presenting the Competencies

Developing Health Promotion Competencies

The use of competency-based approaches can be traced to the early 1970s (McClelland, 1973). Over the intervening decades, the use of the approach has expanded from the human resources context to widespread use in education and employment across a range of organisational and professional settings.

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By the late 2000s, health promotion-specific competencies had been developed in a number of countries, including Australia, Canada and New Zealand (Battel-Kirk et al., 2009; Dempsey et al., 2011a). Globally, the Galway Consensus Conference, convened in 2008, was built on international experience to promote greater collaboration in the development of core competencies in health promotion (Allegrante et al., 2009; Barry et al., 2009; IUHPE, 2009). In Europe, reviews and scoping studies (Battel-Kirk & Barry, 2009) informed the development of a draft competency-based accreditation framework that formed the basis for the 'CompHP Project' (2009 to 2012) funded by the European Union (Barry et al., 2012).

The CompHP Project

The CompHP Core Competencies for Health Promotion[1] (Dempsey et al., 2011b) were developed as the main component of the CompHP Project (referred to as 'the Project'). The Project aimed to develop competency-based standards and an accreditation system for health promotion practice, education and training in Europe that would positively impact workforce capacity in addressing health inequities and delivering improved health outcomes (Barry et al., 2012). The core concepts and principles of health promotion outlined in the Ottawa Charter (World Health Organization (WHO), 1986) and successive WHO charters and declarations (1991, 1997, 2000, 2005, 2009) and international experience in developing health promotion competencies (Battel-Kirk et al., 2009; Dempsey et al., 2011a) formed the foundation of the Project. The definition of health promotion used in the Project was 'the process of enabling people to increase control over, and to improve, their health' (WHO, 1986), and health promotion was viewed as 'representing a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also actions directed toward changing social, environmental and economic conditions which impact on health' (Nutbeam, 1998).

The overriding rationale for the Project was the recognition that a competent workforce, with the necessary knowledge, skills and abilities in translating policy, theory and research into effective practice, was critical to the future growth and development of global health promotion (Allegrante et al., 2009; Barry, 2008; Barry et al., 2009; WHO, 2009). It was also recognised that, while health promotion was an evolving field with a diverse and growing workforce drawn from a broad range of disciplines, there was a specific body of skills, knowledge and expertise representative of, and distinctive to, health promotion practice (Barry, 2008; Barry et al., 2012). Another driver for developing the Project was that there were no agreed competencies, standards or accreditation systems to assure quality standards, despite health promotion goals being identified in European and global health strategies (Battel-Kirk et al., 2009; Dempsey et al., 2011a).

[1] *The 'CompHP Core Competencies' were renamed as the 'IUHPE Core Competencies' in 2016. See 3.1 for details. Each title is used to reflect the time it was used.*

Developing the CompHP Core Competencies

The CompHP Core Competencies formed the first and pivotal element in the Project.

The competencies were developed using a phased, multi-method approach to facilitate a consensus-building process with key stakeholders in the European health promotion community (Barry et al., 2012; Barry, Battel-Kirk and Dempsey, 2012, Dempsey et al., 2011c). This process included:

- A review of the international literature on health promotion competencies (Dempsey et al., 2011a).
- An initial draft framework of core competencies based on findings from the literature review and consultation with project partners.
- Two rounds of a Delphi survey on the draft core competencies undertaken with over 200 health promotion experts from across Europe to reach consensus.
- Focus groups with health promotion experts and other key stakeholders from across Europe involving 25 participants.
- Consultations with health promotion stakeholders across Europe using an online questionnaire and discussion forum with 54 responses.

Each stage of the development process was reviewed by the 24 CompHP project partners from countries with differing levels of health promotion capacity who had experience across the policy, practice and academic sectors in health promotion. An international advisory group of experts with experience in health promotion and in developing health promotion competencies also contributed to the development process. This input ensured that the development process took cognisance of the political, cultural and economic environments that impact health promotion practice nationally and internationally. Thus, while the competencies were developed in a pan-European context, a foundation was laid for their future implementation in other regions.

The definition of competencies agreed for use in the Project was: ‘a combination of attributes such as knowledge, abilities, skills and attitudes which enable an individual to perform a set of tasks to an appropriate standard’. As the competencies are central in developing and maintaining quality in the health promotion workforce, they are described as ‘core competencies’. Core competencies are defined as ‘the minimum set of competencies that constitute a common baseline for all health promotion roles. They are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field’ (Dempsey et al., 2011b).

In the context of the Project, the competencies were designed as assessment criteria for course accreditation and practitioner registration. The competencies were therefore primarily targeted at health promotion practitioners whose main role and function is health promotion and who hold a graduate or postgraduate qualification in health promotion or a related discipline (Dempsey et al., 2011b). However, it was recognised that, as levels of health promotion capacity and professional identities vary, the competencies may be used as a ‘stand-alone’ framework, or in conjunction

with the associated IUHPE Professional Standards (Speller et al., 2012a, b), in some countries and contexts. Dempsey et al. (2011b) indicate that the competencies are useful to other professionals whose role includes health promotion and in informing the development of subsets of competencies for specific settings. The competencies are also recommended as a useful tool for the broader intersectoral workforce who promote health in specific settings or as part of health promotion partnerships, e.g., teachers, environmental health officers, etc.

Based on the reviews of the literature (Battel-Kirk et al., 2009; Dempsey et al., 2011b) implementing the competencies was expected to provide benefits for a range of groups in addition to health promotion practitioners, including other professionals whose role includes health promotion and the wider health promotion workforce, together with health promotion organisations and employers (Dempsey et al., 2011b). Expected benefits included:

- Ensuring that there are clear guidelines for the knowledge, skills and values needed to practice effectively and ethically.
- Informing education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs.
- Assisting career planning and identifying professional development and training needs.
- Facilitating movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies.
- Promoting better communication and teamwork in multidisciplinary and multisectoral settings by providing a common language and a shared understanding of the key concepts and practices used in health promotion.
- Helping to create a more unified workforce by providing a shared understanding of key concepts and practices.
- Contributing to greater recognition and validation of health promotion and health promotion practitioners.

The CompHP Core Competencies Framework for Health Promotion

The CompHP Core Competencies Framework for Health Promotion (Dempsey et al., 2011b) comprises 11 domains of core competency (Fig. 35.1). Ethical values focusing on equity and social justice and the health promotion knowledge domain are depicted as underpinning all health promotion action. The health promotion knowledge domain describes the core concepts and principles that make health promotion practice distinctive.

The remaining nine domains comprise:

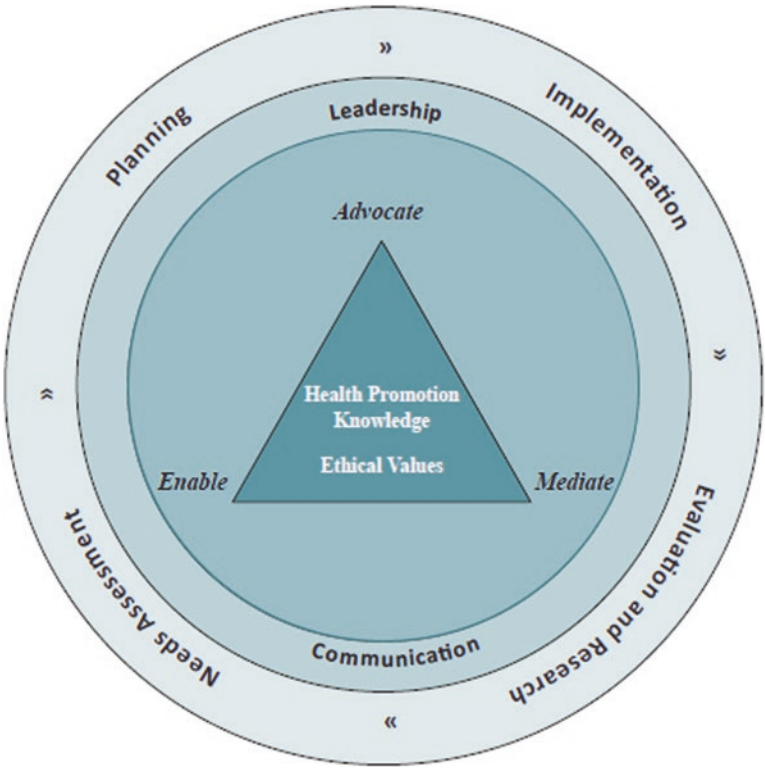

Fig. 35.1 The CompHP Core Competencies for Health Promotion. (Dempsey et al., 2011b)

- **Enable change:** Enable individuals, groups, communities and organisations to build capacity for health promotion action to improve health and reduce health inequities.
- **Advocate for health:** Advocate with and on behalf of individuals, communities and organisations to improve health and wellbeing and build capacity for health promotion action.
- **Mediate through partnership:** Work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion action.
- **Communication:** Communicate health promotion action effectively, using appropriate techniques and technologies for diverse audiences.
- **Leadership:** Contribute to the development of a shared vision and strategic direction for health promotion action.
- **Assessment:** Conduct assessment of needs and assets in partnership with stakeholders, in the context of the political, economic, social, cultural, environmental, behavioural and biological determinants that promote or compromise health.
- **Planning:** Develop measurable health promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders.

Table 35.1 Competency statements – Domain 1 (Dempsey et al., 2011b)

Domain 1 Enable Change - Enable individuals, groups, communities and organisations to build capacity for health promotion action to improve health and reduce health inequities
A health promotion practitioner is able to:
Work collaboratively across sectors to influence the development of public policies which impact positively on health and reduce health inequities
Use health promotion approaches which support empowerment, participation, partnership and equity to create environments and settings which promote health
Use community development approaches to strengthen community participation and ownership and build capacity for Health Promotion action
Facilitate the development of personal skills that will maintain and improve health
Work in collaboration with key stakeholders to reorient health and other services to promote health and reduce health inequities

- **Implementation:** Implement effective and efficient, culturally sensitive and ethical health promotion action in partnership with stakeholders.
- **Evaluation and research:** Use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact and effectiveness of health promotion action.

Each domain deals with a specific area of health promotion practice, and the associated competency statements detail the skills required for competent practice (Table 35.1).

The IUHPE Professional Standards

The IUHPE Professional Standards are based on the competencies and were developed using a multistage consultative process (Speller et al., 2012a, b). The standards were designed to underpin the accreditation process developed in the Project but are useful in other contexts. For example, as each standard states the specific knowledge, skills and performance criteria necessary to demonstrate competence in each domain, they can be used in designing, delivering and assessing education and training programmes (Table 35.2).

Operationalising the Competencies

As intended from their inception, the competencies have been operationalised, in conjunction with the IUHPE Professional Standards, as the assessment criteria for accreditation of courses and registration of practitioners. Accreditation and registration were initially available in the European region from 2013 to 2016 through the European Health Promotion Accreditation System (Battel-Kirk et al., 2012, 2015; Battel-Kirk & Barry, 2013). The European system was expanded to the global level

Table 35.2 IUHPE Professional Standards. Domain 1 – enable change (Speller et al., 2012a)

Standard 1. Enable change – Enable individuals, groups, communities and organisations to build capacity for health-promoting action to improve health and reduce health inequities. A health promotion practitioner is able to demonstrate:		
Competency statement	**Knowledge** and **skills** required include:	**Performance criteria:** *Evidence provided either from documentation or from assessment during work or study of the applicant's ability to:*
1.1 work collaboratively across sectors to influence the development of public policies which impact positively on health and reduce health inequities *1.2 use health promotion approaches which support empowerment, participation, partnership and equity to create environments and settings which promote health.* *1.3 use community development approaches to strengthen community participation and ownership and build capacity for health promotion action* *1.4 facilitate the development of personal skills that will maintain and improve health* *1.5 work in collaboration with key stakeholders to reorient health and other services to promote health and reduce health inequities*	**Knowledge** Theory and practice of collaborative working including facilitation, negotiation, conflict resolution, mediation, teamwork Knowledge of strategy and policy development and how legislation impacts on health Health promotion models Health promotion settings approach Behavioural change techniques for brief advice/ interventions Theory and practice of organisational development and change management Theory and practice of community development including empowerment, participation and capacity building Understanding of social and cultural diversity **Skills** Collaborative working Behavioural change techniques Organisational development Change management Community development including empowerment, participation and capacity building Ability to work with individuals and community groups defined by geography, culture, age, setting, or interest and individuals and teams in their own/other organisations/sectors	1a. Contribute to collaborative work with stakeholders across specified sectors that aims to develop or change policies, or change health and/or other services, in order to promote health and reduce health inequities in a specified area 1b. Identify and select appropriate health promotion approaches to support the creation of health-promoting environments and/or settings in a specified area and show an understanding of how the approaches can support empowerment, participation, partnership and equity 1c. Select and use appropriate community development approaches for a specified community and show an understanding of how the approaches can lead to strengthened participation, ownership and health promotion capacity 1d. Select and use appropriate behavioural change techniques for specified individuals or groups, to facilitate the development of personal skills to maintain or improve health

and formally launched as the IUHPE Health Promotion Accreditation System at the IUHPE World Conference in Brazil, in May 2016. At that time, the System's components – the 'CompHP Core Competencies and Professional Standards – were renamed the 'IUHPE Health Promotion Core Competencies and Professional Standards'.

There are currently IUHPE accredited courses in Australia, Estonia, Finland, Ireland, Italy, Portugal, the Netherlands and the United Kingdom, all of which have successfully demonstrated that they cover all the competency domains. More information on the IUHPE Health Promotion Accreditation System is presented in Chap. 34.

Evidencing the Competencies

There is reference in the literature[2] to the use of the competencies in health promotion education and training across the IUHPE regions.

Evidence from the Literature: Europe

In Europe, consultations on the competencies and accreditation in academic settings (Contu et al., 2012) and practice setting (Gallardo et al., 2012) in the context of the CompHP Project indicated that they were used in some countries within a year of their publication, mainly in health promotion education settings.

In Ireland, McKenna et al. (2011) reported that a reflective portfolio based on the newly developed competencies promoted high levels of reflection, reinforced student learning and identified further training needs. In a different professional context, the National Youth Council of Ireland (2013) used the competencies as the basis for a health promotion training manual for youth workers.

Garista et al. (2015) explored the impact of the competency-based IUHPE accreditation system on pedagogical models and strategies in higher education in Italy and internationally. The authors concluded that deep pedagogical reflection is needed to ensure that health promotion students acquire the CompHP and other relevant competencies.

In evaluating the use and impact of the competencies in Europe on practice, education and training, Battel-Kirk and Barry (2019a, b) reported that the competencies have been instrumental in developing and implementing quality assurance of practice, education and training. Their findings indicated that the development and implementation of the competencies have stimulated a shared vision of what constitutes the specific knowledge and skills required for effective and ethical health

[2] *Reference is made only to the literature available in English.*

promotion practice in different settings. Findings also indicated that the competencies had been used as criteria for assessing knowledge and skills in health promotion education and training. There was evidence that the competencies provide clear guidelines for health promotion knowledge, skills and values in health promotion specific courses, in the education and training of health professionals whose role includes health promotion and in Continuing Professional Development (CPD) across the region. In these contexts, the competencies were described as providing a common language and underpinning a shared understanding of the ethical dimensions and scope of health promotion practice.

In a European survey, health promotion education was rated as the area with the highest use of the competencies and highest expected future use. The highest current and expected impact of the competencies, and evidence of their impact, was also reported in the health promotion education context (Battel-Kirk & Barry, 2019a). Examples of the impact of the competencies included changing curricula in health promotion courses, developing new masters-level health promotion programmes and forming the criteria for the evaluation of CPD. The competencies have also been used as the basis for postgraduate theses and a health promotion handbook (Breton et al., 2020).

A case study exploring the implementation of the competencies in Ireland and Italy confirmed their contribution to health promotion education (Battel-Kirk & Barry, 2019b). In Ireland, the competencies have been formally implemented in health promotion specific courses, education and training for professionals whose role includes health promotion and in CPD – mainly in the context of re-registration of practitioners within the IUHPE Accreditation System. Formal implementation of the competencies in Italy was reported by two university degree programmes that are accredited by the IUHPE, in other health promotion education contexts, in other health-related professional academic courses, in training for health professionals at regional and national level and in the development of an online 'best practice' framework.[3] These findings suggest that the competencies are useful in teaching and learning across health promotion education settings and have the potential for long-term impact on quality assurance in health promotion through students' future practice.

Health promotion education was also reported as a key factor in the implementation of the competencies in both countries. In Ireland, the majority of informants indicated that they became aware of the competencies through health promotion courses and/or health promotion conferences hosted by an academic institution. The leadership role played by Irish academics in developing and supporting the implementation of the competencies was regarded as an important facilitating factor, and graduates of accredited courses were recognised as potential champions for future implementation. In Italy, a lack of health promotion education and training was viewed as a limiting factor in the implementation of the competencies. However, the competencies were suggested as an authoritative source when arguing for more, and

[3] https://www.dors.it/

better-quality, health promotion education and training. Those implementing the competencies in education and training in Italy were regarded as role models for others wishing to develop competency-based curricula, and their role in disseminating information on the competencies was acknowledged.

However, while there was evidence that the competencies had been used and have had an impact[4] on health promotion education, challenges for their future implementation were also noted. For example, Battel-Kirk and Barry (2019a, b) found an overall lack of awareness of the competencies among key stakeholders including academics, employers and policy decision-makers. The issue of language as a barrier to implementing the competencies was also raised, with challenges posed by different cultural and linguistic interpretations of key concepts and core words in the competency context. These challenges indicate that translation of the competencies should be a cooperative endeavour between skilled translators and experts with a solid grounding in health promotion. A lack of experience of using competency-based approaches in educational settings was identified as a barrier to future implementation in some countries. The role that leaders in health promotion education can have in addressing these challenges, and in expanding the use of the competencies across all levels of courses and training, was demonstrated by Irish and Italian educators' endeavours in this regard.

Lang (2020) presented findings from a study undertaken in Austria to establish whether the IUHPE Competencies framework is suitable for evaluating training. Findings indicated that there was a significant increase in health promotion competencies when comparing measurements before and after training. It was concluded that the results justify the creation of a scale to assess core health promotion competencies for evaluating training courses but that some methodological issues still needed to be considered. Sistermans (2020) reported that the competencies were used in formulating interview questions in research undertaken in a Dutch University exploring the integration of competency-based education in online health sciences.

Evidence from the Literature: Other Regions

There is also reference in the literature to the use of the competencies in other IUHPE regions including Africa, Latin America and the Western Pacific (Battel-Kirk & Barry, 2019c). For example, Ekenedo and Ezedum (2013) referred to the IUHPE competencies as a possible source when developing a national competency framework for health promotion in Nigeria. There are multiple references to the use of the competencies in the literature from Latin America (IUHPE ORLA Region) with all originating in Brazil. For example, Moreira and Machado (2020) reported the findings of a Delphi study based on the competencies that informed a

[4] The purpose of the research impact was defined as 'changes attributable to the implementation of the competencies'.

competency matrix incorporating national policies suitable for use in health promotion training for professionals in diverse settings. Netto and Silva (2018) referred to the competencies when analysing health promotion in nurse training programmes. Xavier et al. (2019) explored the literature about the CompHP competencies and concluded they are an important reference for health promotion training in Brazil. Pinheiro et al. (2015) and Tavares et al. (2016) also considered that the competencies, while developed in Europe, were valuable to health promotion training in Brazil.

In the Western Pacific region, Hall (2014) examined the development of a competent health promotion workforce globally, with reference to pedagogical strategies and competencies at national and international level, including the IUHPE competencies.

Applying the Competencies: Examples from the Field

Sources of Information

The information presented in this section draws on analysis of data from two main sources:

- Feedback from leaders of IUHPE-accredited courses who were contacted by the authors via email in March 2021 and asked to share their experiences of using the competencies and their opinions on their usefulness. A total of eight course leaders responded, and their responses were analysed using systematic analysis (for more information on this analytical process, see Battel-Kirk & Barry, 2019b). Direct quotes from those who responded are provided to give insight into each theme identified.
- Unpublished data collected and collated in a PhD study (Battel-Kirk, 2020) that used a two-phased mixed-methods design informed by findings of a scoping review of the literature (Battel-Kirk & Barry, 2019c). The study included an online survey of those involved in the original consultations undertaken in developing the CompHP Competencies, augmented by snowball sampling across the wider European health promotion community. A qualitative case study focusing on the implementation of the competencies in two embedded units of analysis (Ireland and Italy) was also undertaken (Battel-Kirk & Barry, 2019b). The initial case study sample comprised five national experts from each country who were familiar with the practice context of health promotion, including leading members of national health promotion professional and academic bodies and others in health promotion/public health departments and statutory/non-governmental organisations with a remit for health at country level. These experts acted as key informants and members of a National Reference Group in their country and assisted in identifying additional key informants to be interviewed in their country. A total of 13 interviews were completed in each country. Recordings of the

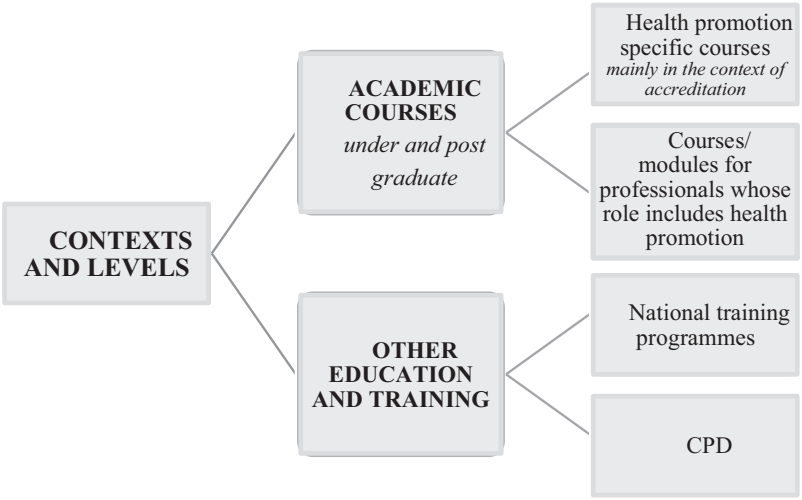

Fig. 35.2 Educational contexts and levels where the IUHPE Competencies used

interviews were transcribed, and the data was analysed using thematic analysis. Informants' own words were included to 'tell the story' underpinning the identified themes.

The information on the use of the competencies presented in this section covers a range of educational levels and contexts (Fig. 35.2).

The feedback on the use of the competencies was collated and analysed. Five key areas of use were identified in marketing courses, structuring courses and programmes, underpinning teaching and learning, supporting interdisciplinary education and partnership and underpinning educational research (Fig. 35.3).

Marketing Courses

Feedback from educators refers to the competencies as useful in marketing their courses to students, employers, funders and other stakeholders. For example:

> *We had run into a real problem…people didn't know what health promotion was…prospective employers didn't know what it was, prospective students didn't know what it was… so for us having a kind of statement of what it is and what the health promotion profession aspires to is really valuable.*

Reference was made to engaging key stakeholders, including funders, in developing health promotion education and training based on the competencies

> *I based the course on these competencies and used them in focus groups with my main stakeholders and we planned the academic curricula mainly on the IUHPE Core competencies.*

Educators suggested that as the competencies were developed and are recognised internationally, their use gives credibility and validity to courses which is a 'selling

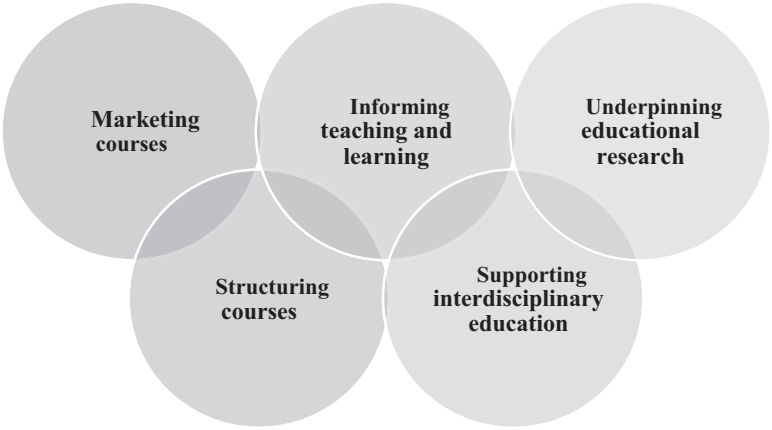

Fig. 35.3 Key areas where the IUHPE Competencies are used in health promotion education and training

point' when marketing courses to stakeholders, including employers. In one example, the competencies were used to structure a new course that was contextualised in relation to national programmes and policies to that met funders' requirement:

> *I used the competencies and then I used some national policies with a focus group with the regional decision makers who were the funders… they wanted some professionals that were able to do specific things.*

Structuring Courses

Much of the feedback focused on using the competencies in structuring courses and training. Educators felt that the competencies gave a strong structure to health promotion education and suggested that competencies structure 'the start, the middle and end of a health promotion course', for example:

> *They helped us re-evaluate some of the things we were planning on the programme and where really found them useful was on the practical competencies… like developing advocacy skills …things that would be a bit more difficult to do in a traditional classroom setting. They made us think creatively about how we could do those things that were outside the traditional classroom setting.*

In one health promotion-specific course, a professional practice module was structured to help students plan, implement and evaluate a practical project in order to understand how the competencies are applied in practice. There was also reference to students mapping learning from across modules against the competencies:

> *(Students) map learning from other modules against the competencies…so if they have done something in another module…like facilitated a group… they can describe their learning within the competencies.*

Another course was structured to enable students to demonstrate how they develop the skills, knowledge and attitudes related to each competency domain. The

students initially refer to the competencies in a personal professional development plan and then develop a competency-based portfolio.

Using the competencies to structure and contextualise external lecturers' input to health promotion courses was also described:

> *We invited someone who was involved in public health policy regarding alcohol to talk about his experience of advocacy. When I invited him, I sent him the information on the competencies and explained them. I do that with all the people who come in so that they know the context of what we are asking them to talk about.*

Some health promotion lecturers reported that they use the competencies when structuring their contribution to teaching with other departments and disciplines. There was specific reference to the usefulness of the competencies in structuring education for professionals whose role includes health promotion. For example:

> *The competencies are hugely valuable in terms of framing (courses) … they really help the students to get what it is really all about…. they are used in the Social Care Programme…. people come out as Social Care workers – but the competencies are integral to the health promotion elements of the programme*.

Reference was also made to the competencies underpinning specialist postgraduate programmes developed in partnership with a national department of health and non-governmental organisations. The courses focused on issues such as workplace wellness and mental health promotion and were advertised as suitable for a variety of professions and settings

In some instances, the competencies were adapted for specific settings, for example, to guide the curricula for a group of professionals tasked to implement a regional health promotion plan:

> *They gave us the framework (competencies) and then we could adjust and adapt to the local context… to me they were very useful and the idea that they are they have been built on many different peoples' experience … I felt that it was a strong tool to base our training plan on.*

The usefulness of the competencies was strongly endorsed by one lecturer who used them to guide teaching and ensure that students understand health promotion:

> *Health promotion is not exactly the main focus of my teaching, but I am very passionate about health promotion, so I use (them)… I want that the students have that approach of health promotion in their work so when I teach, I use the competencies.*

Underpinning Teaching and Learning

There were many references to the use of the competencies in the education setting when explaining health promotion and its unique contribution to population health, for example:

> *They are very useful as they give students a context for what people working in health promotion do. One of the questions that I ask students is 'you are at a party or social engagement and someone asks what do health promotion people do? Initially students think that people give out leaflets and that type of thing. The competencies provide insight into the*

skills that are required or used, and they also give framework for students in terms of how they develop their skills in health promotion.

A recent graduate of a health promotion course highlighted the usefulness of the competencies in student learning:

From a student perspective they were absolutely useful. We had to complete projects on each of the competencies to demonstrate our understanding of them. We had to do reflective work on some previous experience…like communication or one of the other domains… and that really helped us get a deeper understanding of each competency.

One lecturer described how students use the competencies in their curriculum vitae (CV) to showcase their learning and highlighted the fact that the transferability of the competences they had developed is evident in the CVs:

Some of them have arranged their CVs showing the competencies… structuring it to show the skills they have built and many of these are very transferable outside of the direct health promotion roles … so they have concrete examples under planning, communication, partnership work…it was a nice thing to see that they that is how they have viewed their learning and be able to present it as well.

Innovative ways of using the competencies in different learning contexts were described. In one university, for example, students use the competencies in projects linked to healthy campus initiatives. Another lecturer described asking students to imagine they are implementing an intervention reported in peer-reviewed article and to then identify the competencies required for its effective and ethical implementation. Using job descriptions to help students understand the competencies was also reported:

Students look at (current) job descriptions and we ask them to see how many of the competencies they can identify and what aspects of them are contained in the job description. It's relevant to learning on the competencies but they also get to see what is out there in terms of the health promotion workforce.

The competencies have also been used in the context of students' experiential learning in work placements, for example:

In the Masters for Health Promotion…the practice module is built absolutely around the competencies and has a placement element so it is a lot of experiential learning. The assignments all reflect that, and the students have to reflect on their knowledge of the competencies and also their observation of them in practice. There is also a short interview where they have to reflect and comment on the competences across the whole of the programme and in their workplace or workplace experience.

Educators reported that they liaise with work placement staff to ensure they are aware of the competencies in order to facilitate the students' placement experience, described as:

We have a workplace placement and part of the requirements is that students get the opportunity to either observe or participate in activities that are framed by the competencies… so all (of the people) in our work placements need to know about the competencies.

The competencies were considered a key resource in building workplace-based learning opportunities for those already working in the field:

> *I introduced the competencies in regional training when mapping training, professional education courses and the field experiences of a group of Health promotion operators.*

In relation to CPD for those in practice, one university reported that:

> *In terms of offering training we are advertising that we are building competence with staff who are in the workforce and we relate that to the competencies.*

One educator commented on the usefulness of the competencies when reflecting on their own skill levels when planning professional development and updating their professional portfolio:

> *They (the competencies) give you an opportunity to reflect on your skills and while you could tick most of them you can also identify gaps… if you are not using them you need to keep refining them…so they are good in terms of professional refection and looking at your personal development plans.*

Reference was also made to using the competencies as the basis for CPD for health promotion practitioners applying for re-registration in the IUHPE Health Promotion Accreditation System (see Chap. 34 for more details)

Developing Interdisciplinary Work and Partnerships

The use of the competencies in developing interdisciplinary education and health promotion partnerships in educational contexts was reported, including in developing health promotion partnerships with the private sector. The competencies have also been used to create interdisciplinary awareness of health promotion's role in global health, for example:

> *We are trying to increase the interdisciplinarity of our work … about global health issues and it being everybody's business and not just the role of health promoters in the college… is a way to bring the competencies in because they are core to all engaging in this work.*

The programmes of an annual multidisciplinary summer school conducted at postgraduate level that focuses on developing practical and theoretical tools to enhance health promotion strategies in Europe state that these are informed by the competencies.[5] The course is targeted at 'people from fields of health promotion, public health, local government, nongovernmental organisations' and 'urban planning, academia, social work, research management, practice and policy'.

The important contribution of the competencies when drawing together different disciplines in health promotion training programmes was also highlighted:

> *We are trying to make a collaboration with universities to share these competencies. We accept students from different stages and sectors… from psychology, from social work and we try to share and disseminate this way of working that is in line with these competencies.*

[5] https://etcsummerschool.wordpress.com/

The competencies were also recognised as useful in drawing together the 'many strands' of health promotion in educational settings, for example:

> *I think people can find it quite difficult to describe their work in health promotion but if you are using those active verbs people understand - they can relate to it and see the pathway. I think if we are ALL using the same language that again is going to be really beneficial… and the competencies can help bring that together across professional groupings.*

Supporting Educational Research

Reference was made to using the competencies to support educational research, for example

> *We have a health promotion Research Centre…we call it the Knowledge Network… it's not particularly formal…it's with the health service, other health promotion people, NGOs representatives and we talk about the competencies there as well.*

The competencies had also been used to support research partnerships:

> *We work with different research partners on research projects … there is a range of people working on that and we stop often and talk about the way that we work and the core competencies have been useful there as a reference.*

The competencies are referred to as one of the guiding principles of facilitating knowledge transfer and exchange (KTE) by a centre in Italy that provides data, scientific evidence, models and tools, good practices and training to plan, manage and evaluate health promotion and prevention interventions The centre also uses the competencies as criteria in assessing models of good practice.[6]

Conclusion

As indicated in the literature and feedback from educators, the IUHPE Competencies are used and are regarded as useful, in health promotion education, both in teaching and learning in health promotion-specific courses and in education and training for other disciplines whose role includes health promotion. There is also evidence of their usefulness in developing interdisciplinary education and partnerships with other sectors, including in academic research. The evidence suggests that implementing the competencies has had a positive impact on health promotion education by contributing to quality assurance, promoting consistency in teaching and learning and in marketing education and training to students and other stakeholders. Research also indicates that health promotion educators have a role to play in raising awareness and promoting the use of the competencies as the basis for quality

[6] https://www.dors.it/

assurance in teaching and learning that will foster efficient and ethical health promotion practice in future generations of health promoters.

Table 35.3 brings our reflection on the six triggering questions suggested by the Editors.

Table 35.3 Authors´ reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	The IUHPE Core competencies build on the core concepts and principles of health promotion outlined in the Ottawa charter and successive WHO charters and declarations on health promotion. Core competencies for health promotion provide quality assurance for the workforce to ensure health promotion practice is a comprehensive social and political process which embraces action directed at strengthening the skills and capabilities of individuals and toward changing social, environmental and economic conditions which impact on health.
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	The international experience regarding the development, implementation and evaluation of health promotion competencies covers a range of participants, contexts and setting. The development process included consensus building with key health promotion individuals and agencies with input from international experts in health promotion competencies. Feedback from students, academics and practitioners in different countries and regions on the use and impact of the framework is included. In addition, examples of the use of the framework in different academic courses are offered as suggestions regarding their future use. The chapter also includes reference to the relevant literature at the global level.
Which theories and methodologies are used in the teaching-learning process?	Health promotion theory and practice as defined in WHO charters and international literature provide the foundation for the internationally agreed IUHPE core competencies that are proposed for use in designing, delivering and assessing health promotion pedagogy.
What kind of forms of assessment are applied, results achieved and challenges faced?	Reference is made to the use and use of the comp Core competencies in assessment of course work and practice-based learning and in evaluating courses.
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	The IUHPE Core competencies as the basis for teaching and learning in educational and training programmes for those whose role are focused on health promotion and other health professionals whose role includes health promotion.
What others could learn with your experience? What is localised, and what is "generalisable"?	The learnings from the literature and experiences of using internationally agreed competencies for health promotion education and training are generalisable across disciplines and contexts. The competencies, while designed for primarily for health promotion practitioners, have been shown to be useful as the basis for quality assurance in health promotion in different contexts and settings.

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Chapter 36
Brick by Brick: Building a House of Health Promotion on a Foundation of Political Science Theory

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Introduction

Until recently, the Department of Political Science at the University of British Columbia (UBC) had never offered a course on the topic of public health. Here, we examine the department's first course, 'Global Politics and Health', through a Scholarship of Teaching and Learning (SoTL) lens, taught by first author Dr. Farah Shroff.[1] Our goal was to determine whether political science students, as a result of the course, gained a sense of agency in public health issues. This systematic inquiry resulted in powerful lessons about the purpose of teaching public health and created long-lasting shifts in both content and teaching techniques. While many teachers reflect upon their teaching, an SoTL inquiry is in-depth, thorough, and carried out within the context of literature in the field. As the link between global health promotion and political science is often misunderstood, a primary challenge of teaching health promotion is to decouple concepts of health with those of medicine.

Theory and Background

It is counterintuitive to most people that health issues are deeply rooted in social, political, environmental, and economic issues (Lucyk & McLaren, 2017). A majority of Canadians believe that better health is based on more medical care (Crémieux et al., 1999), yet this is inconsistent with evidence (Bryant et al., 2011). Worldwide, those who hold less financial and social power experience worse health outcomes as a result of limited access to education, clean water, housing, social services, and so forth (Claessens & Feijen, 2006) as more money and power are equated with better physical and mental health (Bosworth, 2018).

The biggest levers for improving population health status are thus structural ones, such as progressive taxation, social programmes that fund those in financial need, and large-scale cultural shifts that bring about equitable opportunities for those on the margins of society such as people with disabilities, Indigenous and

[1] This chapter is significantly longer and a more ample version of our journal article: Shroff et al. (2022).

other racialized communities, women, LGBTQ2+ folks, those living in poverty, and others (Lee & Sadana, 2011).

Few theoretical constructs underpin the field (Calzo et al., 2018), thereby providing minimal bedrock upon which to teach public health theories. Gender, a significant consideration for approximately half the global population, is a topic often lacking in public health teaching and analysis (van Hagen et al., 2020). Similarly, colonial and Eurocentric models of global public health continue to be the norm, perpetuating notions that European and European diasporic approaches to health and wellbeing are superior to others and can *save* those in the Global South (Fofana, 2021). These topics overlap with political science topics.

More diverse educational models are required in order to adequately represent the multilayered and complex reality of population health. Models from political science could help to inform this understanding.

Moreover, behaviourist theories, predicated upon the importance of individuals making lifestyle changes in order to improve their health, are the norm in North American public health curricula (Harvey & McGladrey, 2018). Ecosocial theoretical constructs, informed by political theory, that embed an understanding of macro issues determining community health status, embracing environmental, economic, social, and political issues, complement behaviourist models well. Health status is an interplay between structural and individual realities. Eliminating poverty/social inequities *and* adopting a healthier lifestyle improves health. Within biomedicine, individualist approaches to improving health dominate conventional discourse; this is mirrored in many North American public health curricula, in contrast to Latin American medical and public health curricula which embrace the importance of both individual and collective efforts to improve health (Waitzkin et al., 2001).

Many are calling for improvements to public health teaching through the adoption of critical andragogy that engages in transformative learning (Mabhala, 2013). This vision of public health is rooted in social justice principles that promote health equity through actions on the social determinants of health such as policy changes, progressive social programmes, and so forth. Virtually all these tasks are within the purview of political scientists, sociologists and other social scientists.

Ecosocial transdisciplinary models of public health offer a rich analysis of the interplay of social, economic, political, and environmental factors related to public health, as opposed to exclusively individual-level health indicators. Latin American public health curricula more fully embrace these models along with qualitative and social science epistemologies. Cuban public health curricula, for example, typically include political economy and other aspects of social sciences.

Public health practice, moreover, often lags far behind public health policy. This policy–practice gap is well articulated through social science theoretical frameworks (Gagnon et al., 2017). In this course, bringing public health to students in political science is one way of creating a relationship between these two fields.

Teaching public health in an interdisciplinary fashion that underscores the intersectoral and collegial nature of the field is vital (Chávez et al., 2006). The overarching premise of the course was that *global public health is politics writ large.* Most Canadian Political Science courses in the field of health focus on medicine (Jacques,

2012). In contrast, our course emphasized the social determinants of health including income, social equity, housing, education, water, sanitation and analysed mental health issues, women's health issues, sexuality, and HIV. Case studies on Brazil and Rwanda illustrated how better health came about as a result of government policies that improved social and economic conditions. Establishing the notion that the foundations of public health are deeply political, we aimed to encourage students to develop confidence in defining health as well-being and establish a better understanding of health equity.

Course Design

The main course goals were to build an understanding of social determinants of health and health equity through politics (income distribution and social justice for marginalized groups). These were articulated in the course objectives, which were to:

1. Identify sociopolitical determinants of global population health status and demonstrate an understanding of political levers that impact health.
2. Apply previous knowledge in political science and international relations to global public health issues.
3. Analyse the concept that global public health is politics writ large and that political will is the foundation of large-scale population health status improvements.
4. Connect current political issues with topics in this course.
5. Create global health solutions that integrate political processes.
6. Think of 'out of the box' solutions to global health problems, using creative media and techniques.
7. Synthesize ideas about the political foundations of community health to reimagine possibilities of a career or future work that integrates political science and public health.
8. Care about the health of all people in the global village.

Relationships to Health Promotion Competencies

These objectives relate to numerous Health Promotion Competencies (Pan-Canadian Health Promoter Competencies and Glossary, 2015). Many of the competencies such as understanding the social determinants of health and implementing changes so as to take action on these determinants were explicitly part of the course as evidenced in Objective 1 above. Many other health promotion competencies, such as situational analyses, were implemented in the course through group projects. One group project was on breastfeeding in Canada and the importance of raising current breastfeeding rates. The students analysed multiple factors related to improving

breastfeeding uptake, such as the normalization of mothers feeding their babies in public, creating new norms to acknowledge the multiple biological functions of the female breast, including food for offspring, sexuality and pleasure. Students analysed cultural assumptions that the female breast is primarily a sexual object, grappling with root causes of breastfeeding hesitancy.

Connecting course objectives 4, 5 and 6 to the Health Promoter Competency 'planning and evaluating health promotion action', student projects explicitly demonstrated this competency. One group, for example, examined drug addiction, proposing the legalization and distribution of medical-grade heroin as a harm reduction strategy for addressing this crisis in Canada.

Case Studies

Case studies on Brazil, Syria, and Rwanda illustrated the multidimensional nature of governance, democratic processes and political transformation's impact on community health status. Multiple course goals were achieved through these case studies, one of which was that political science graduates who work for governments, nongovernmental organizations and other 'non-health' agencies may have a major influence on population health status.

The Rwandan case study focused on the successes of the Rwandan government on improving population health. Vision 2020 was an ambitious plan created by the newly formed government to rebuild the nation on solid foundations of democracy, good governance and gender equality, all of which influence health status. In 20 years, Rwanda successfully increased literacy rates, decreased infant and maternal mortality rates, improved quality of healthcare, doubled life expectancy (since 1994), and significantly increased access to health services (Redifer et al., 2020). Rwanda has become a leader in the East African region, in many areas, including in health care insurance coverage. Over 90% of Rwandans today have some form of health care insurance (Muremyi et al., 2021).

To illustrate concepts from course readings and videos, a public health professor from the University of Rwanda spoke in the classroom, providing students with examples from his own life about the great changes he had experienced. He recounted, for example, childhood memories of walking in Kigali, accidentally stumbling upon corpses. Today, Kigali is one of the cleanest capitals in the African continent. Rwanda was selected as a case study partly because many people only think of genocide when Rwanda comes to mind. Few Canadians are aware of the phenomenal advances that the nation has made in less than a generation.

Furthermore, by analysing new topics for political science students such as mental health and childbirth, we aimed to provide students with conceptual frameworks to articulate health issues, realizing their role as agents of health promotion. In reflecting upon agency as a central concept in the course, the teaching team also realized their own agency, besides discovering the depth of impact they can have on students' intellectual and personal lives.

Teaching Philosophy

The teaching team was inspired by Freirian notions of *education as liberation* (Freire, 1998), equipping students with critical intellectual tools, to live with self-determination, experiencing, and spreading kindness and justice.

Much of Freire's philosophy was taken to heart in this course. This philosophy calls upon teachers to become themselves. Role modelling good health, self-knowledge, and self-love is key to applying this philosophy. As Freire noted, 'Whoever teaches learns in the act of teaching, and whoever learns teaches in the act of learning' (Freire, 1998, p.31). Continuous learning is a key part of renewing oneself as an educator. The students in this course were excellent teachers. 'Education is an act of love and thus an act of courage' (Freire, 1973, p.38). In many ways, teaching is similar to parenting. Students, somewhat like our children, become part of our larger family. Loving our students and loving this work are key parts of our teaching philosophy. In hierarchical ivory towers, this is an act of courage.

Methods

The purpose of this study was to assess the impact of this course on students' sense of agency as actors in the field of health. Specifically, could one course stimulate sustained curiosity in health issues?

This course evaluation assessed student interest and knowledge of global health promotion issues, and investigated whether student agency increased as the course progressed. To measure these factors, we acquired student reports thrice throughout the course: (1) a pre-course survey, (2) a midterm survey, and (3) an end of term survey. The surveys were all conducted online via the FluidSurveys platform. By having students complete a survey at numerous points during the term we were able to conduct within-subject analyses to examine how individual students' perceptions changed as the course progressed. Most questions were unique between surveys, as the increase in acquisition of course content allowed for content-specific questions. We also assessed open-ended qualitative questions and analysed them using Framework Theory (Gale et al., 2013). Using this structure, we were able to analyse the impact of this course through different modalities to comprehensively assess outcomes.

The Behavioural Research Ethics Board at the University of British Columbia (Vancouver campus) deemed that this project was exempt from requiring an ethics certificate, as the primary purpose was course assessment and evaluation. Regardless, this study followed ethical protocols and institutional guidelines for research.

The survey questions assessed three key aspects of the student's experience:

1. Student interest in topics related to a public health course
2. Student understanding of health and the determinants of health
3. What impact the course had on the student's life and sense of agency (e.g. personal, social, and future behaviour)

The surveys were completed for course credit: 2% was allocated to the first survey, 5% was awarded to the post-course survey, and the midterm survey was not awarded a participation grade. Student identifiers were removed prior to analysing the data and each student was given an anonymous, unique code.

Pre-survey

The pre-course survey was emailed to students several weeks before the term began. The survey consisted of 14 questions relating to their interest in global politics topics, health and governance, conceptualizations of public health, interest in global health promotion, previous thoughts and experiences with health issues and political health issues, thoughts on the connection between politics and the health of populations, awareness of the social determinants of health, and how they considered health promotion issues to be relevant to their future career plans. A majority of the questions required open-ended answers which allowed for qualitative analyses of responses. Some of these items included: 'What does public health mean to you?', 'Have you ever examined political issues related to health? (Please explain.)', 'As a student of politics/international relations, to what extent have you considered public health issues to be relevant to your future work? (Please explain.)'. The five quantitative questions also allowed for follow up qualification of the response. These included questions related to their interest in global public health, previous experience with the topic, and the potential for public health to be relevant to their future work.

Midterm Survey

The midterm survey consisted of eleven questions – most were repeated from the pre-survey – with the goal of measuring changes in perceptions or interest in global health promotion after half the course was completed. We anticipated that many students would come into the course with a medicalized definition of health, and were curious as to whether this perception had changed. To assess this, we asked students to define social determinants of health in their own words.

Furthermore, we were interested in whether students were gaining a sense of agency in terms of their potential role in the field of health. This was assessed by repeating the question from the pre-course survey: 'Please add any other thoughts you have on the relationship between politics, global health, and your future career plans' (These questions were repeated at the end of term). Finally, because this was a new course, we wanted to determine whether certain course components were engaging students to learn in-depth concepts about global public health.

Final Survey

The final survey was emailed to students after the last session of the term. It contained 22 questions about specific aspects of the course and potential changes in student perceptions of public health and to examine a broader definition of agency in health issues to encompass students' personal, community and professional lives. We learned that this course opened up a wellspring of conceptual, emotional, political, and other ideas that were new to most students, given that most had not formally studied health before. Students were asked, for example, to indicate how specific aspects of the course helped them to re-imagine their role in public health and alleviating social inequities. We hoped that the final survey would capture the full impact of the course on students' experiences and understandings of health.

This survey repeated many items from the pre-course and midterm survey to assess changes in student interest and understanding in global public health and governance as compared to earlier in the term. As with the prior surveys, we were also interested in the ways in which students were gaining a sense of agency, in terms of their academic and personal life.

Assessments

We assessed students learning through quizzes, weekly reading assignments, participation in class, and capstone projects. We provided many small forms of assessment that offered low stakes opportunities for students to demonstrate comprehension of course material. Influenced by literature on educational effectiveness, we refrained from exams or high-stakes assessments.

Participants

Twenty students were enrolled in this upper year seminar course, and all but one student completed every survey. Most were enrolled in the International Relations programme. There were 9 male presenting and 12 female presenting students enrolled in the course, and the age range of the students appeared to fall within that of a typical undergraduate course at UBC (between 20 and 30 years old). Additional student demographic information was not collected as it was not relevant to our assessment of the course and student experience questions outlined above.

Results and Discussion

Statistical analyses were conducted using RStudio statistical software.

Students' Foundation in Public Health

The majority of students did not have much formal knowledge in this field (Fig. 36.1). Although they thought that health and politics were linked, most students were unable to explicate this connection.

Building a Definition of Health and Conceptualizing Social Determinants of Health

Many students came into the course with the idea that health and medicine were very similar concepts. Most of the answers in the pre-course survey linked health to access to care, or directly to medicine. One student's definition of health included:

> …the healthcare system that the government is supposed to provide, protect and finance. This includes… hospitals, clinics, helicopters, ambulances… pharmacists, doctors and nurses'. Another stated, 'public health is [a] concept that encapsulates a society's ability to provide adequate care for its population.

From the start of the term, readings, classroom discussions, and lectures focused on defining health as a positive concept related to well-being. Through quizzes and assignments, it became evident that even after a few weeks, students continued to conflate health with medicine. The faculty member (Shroff) made a concerted effort to further clarify the difference between well-being and the absence of disease and access to medical care.

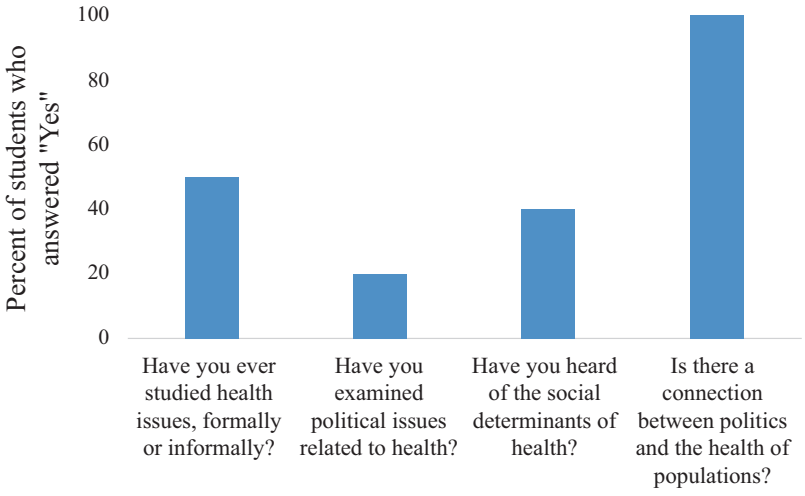

Fig. 36.1 Descriptive statistics from pre-course survey ($N = 20$)

By the time we asked the students to reflect at the midpoint of the course, we felt confident that this foundational understanding was cemented. One student noted:

> When I think about "health," I think not only about physical and mental wellbeing, but now that I am more familiar with the Social Determinants of Health, I now think about other factors that contribute to the definition of 'health'.

This student contrasted their previous perceptions to their newfound understanding of the social determinants of health:

> I have learned more and more that the difference between us is not necessarily genetic luck or individual choice but determined by social factors such as early childhood development, environment, income and education. As I take the journey of this class, health has become more and more intertwined with politics in my mind.

Creating a Public Health 'Scaffolding'

Over the course of the semester, students who had hitherto known very little about public health issues, were able to significantly develop fluency on the topic. They were able to articulate, for example, the great strides that Rwanda and Brazil had made, buttressed by vigorous political will. In relation to the impact of the case studies, students commented over and over that they were surprised by the transformation in Rwanda in particular, and the opportunity to meet a Rwandan public health expert was a highlight of the course for them.

Figure 36.2 illustrates the notable gains in knowledge that students displayed throughout the twelve-week term.

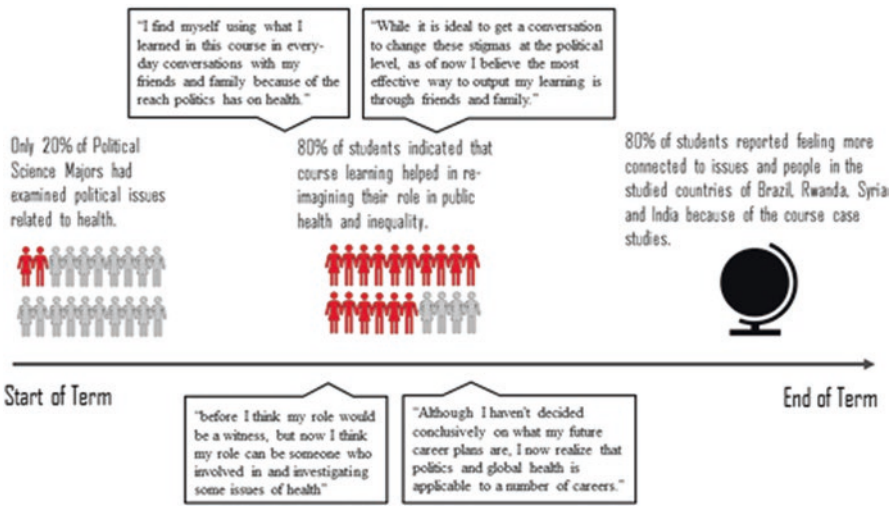

Fig. 36.2 Students' development of agency related to concepts of public health

In the final survey, students indicated changes in knowledge, attitudes, or practices (KAP) towards course issues and topics. Figure 36.3 illustrates the percent change reported for each subtopic. Comparatively, students' KAP shifted most in learning about the social determinants of health, child-bearing practices, and public health solutions.

Students expressed a sense of their own ability to make changes in the realm of public health as researchers, as voters, as witnesses and creative solution makers:

> This course helped show me how I can have agency in the battle for public health. A good example was the two bicycle projects: Bicycles for Humanity and Bicycles Against Poverty, where a relatively innocuous project could have major implications on the health of a population.

> The aspect of this course which I found most amazing was the creative solutions to many problems. We are almost raised, in a way, to believe that ill-health means little access to health care. However, this class shows us that is not necessarily the case. Moreover, some of the problems people face everyday are extremely complex, and traditional solutions do not always appear adequate.

> Before I think my role would be a witness, but now I think my role can be someone who involved in and investigating some issues of health

> The course helped me re-imagine the importance of simply voting in an election can have in shaping future policy, even if I do not pursue a career in politics.

Many students expressed their surprise that they had learned very little about Indigenous politics in the Canadian nation state as well as the historic role of

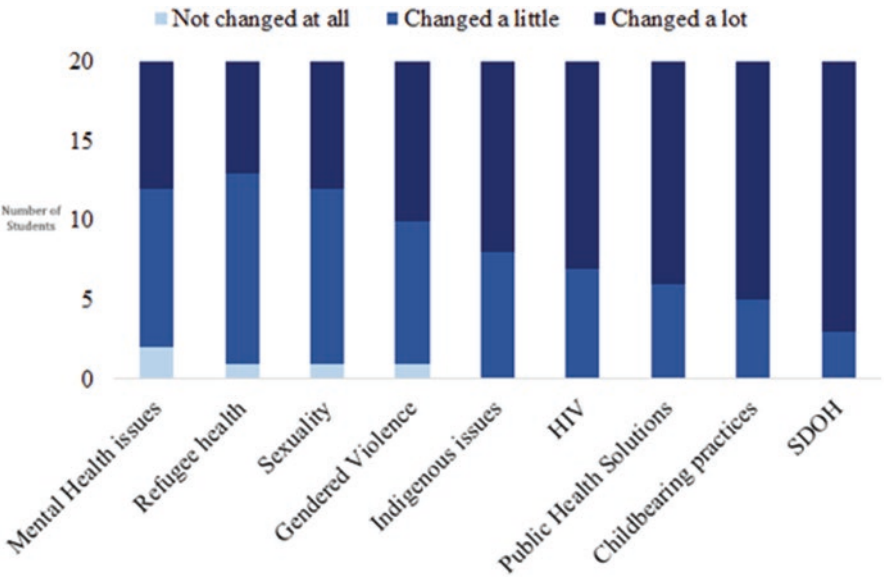

Fig. 36.3 Changes in knowledge, attitudes, or practices in relation to course topics ($N = 20$)

Western European nations around the world and that this was the first course to introduce these topics:

> I've learnt quite a bit about colonialism as a determinant of health- something I had previously never fathomed could play such a large role and have such dire consequences.

Student interest in global public health across the semester is plotted in Fig. 36.4. To determine whether interest changed over the course of the term, a repeated measures analysis of variance was conducted. This analysis indicated that interest changed significantly over the course of the term [$F(2,37) = 3.82$, $p = 0.03$]. Follow-up analyses indicated that this difference in scores was driven by students reporting significantly more interest at the end of the term as compared to the start of the term [$t(19) = 2.46$, $p = 0.02$].

Cultivating Students' Agency in Health

One of the main purposes of the course was to engender students' fluency in public health concepts. Once students grasped broad concepts surrounding the political nature of the social determinants of health, the capstone projects gave them an opportunity to apply their learning to health promotion problems. When asked whether the course helped students to re-imagine their role in public health and inequality, 84% ($n = 16$) responded yes. One student noted that 'before I think my role would be a witness, but now I think my role can be someone who [is] involved in and investigating some issues of health'.

This shift from bystander to agent was reflected in 70% of students indicating that their response to a health-related situation would be different now compared to before the course. One student was prompted by the current opioid crisis in Vancouver to take action, noting that 'the topic inspired me to physically attend a Naloxone training session and actually be able to do something should I ever encounter someone who has overdosed. In that way, this course inspired me to learn a new skill and enriched my learning'.

Moreover, most students were inspired to sharpen their skills in political analysis related to health issues. Virtually, all students agreed strongly (mean rating 4.7/5)

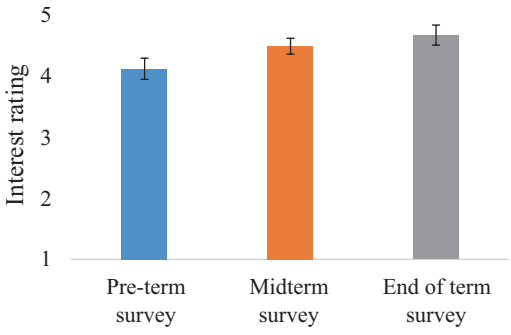

Fig. 36.4 Student interest in the topic of global public health as the course progressed

that policy makers and other political science professionals are potential agents of change in the field of health. Students clearly demonstrated their conceptual understanding that health, politics, and jobs are connected.

During the initial conception of the course, we placed a great deal of focus on how it would impact the students' career plans. As the course progressed, we heard formally and informally from students that they benefited tremendously from understanding mental health issues in their own lives and those around them.

> I've learned that it's okay to not be okay. So many people struggle with different issues and we don't have to just shut up and pretend like nothing is going on. Going to therapy isn't always a solution, taking medication may not work either ... It is hard to realize that people close to you, people that you love, have suffered so much through no fault of their own.

> The course subject matter has encouraged me to look at health issues in my own life and recognize that I have agency to make positive changes in my lifestyle to create better health outcomes, while many others in more difficult situations do not have this freedom and privilege to.

Bridging the cognitive and affective domains in public health education practice is possible, yet not the norm, because most teaching relies upon didactic teaching methods. Students spoke earnestly about their particular circumstances – reflecting upon privilege, stigma, spiritual and emotional well-being – and how this course provided them with a framework for re-imagining adaptive mechanisms for themselves:

> I have come to learn that the mental and physical health issues I face are directly linked to my social environment. As an international student, a sense of belonging is hard to achieve especially since it is hard to make and maintain friends. I have come to learn the importance of having people around you (a support network) and how that is able to affect your mental well-being. Being far away from family and friends at home have left me with a smaller support network here in Canada. After taking this course, I have decided that I will try participating in school activities to try and expand my social circle.

> I realized that my mostly positive health status hasn't been attributed to my gene pool only, but rather is a result of my upbringing and my privilege. This class has also encouraged me to pay attention and take care of my mental and spiritual health, which I previously took for granted. It has also helped me to de-stigmatize any mental health issues I, or people around me face.

For most of them, this was the first time they were given tools to unpack health situations using theoretical frameworks that reduced fear, blame, and shame. One student highlighted how the course provided a framework for interpreting topic such as a family member's mental illness.

Public Health Solutions

The course aimed to provide students with optimism and hope for a healthier world. Lectures, readings, guest speakers, capstone projects, and other aspects of the course constructed mechanisms to address health promotion concerns and increase students' agency in assuming an active role to address public health problems.

Students learned about health promotion solutions based on a foundation of political will through case studies about health governance in Brazil, Rwanda, and Syria. Students were inspired by Rwanda in particular, as the post-genocide era appeared rather bleak. They learned that determined efforts of the new government created more rights for women, campaigns for social harmony, improved access to education and water, while it decreased corruption and so forth. These reforms have raised per capita income, increased life expectancy, reduced child deaths, and created a healthier society based on a stronger economy and greater social unity (Abbott et al., 2017; Dhillon & Phillips, 2015).

Likewise, Brazil, from 2000 to 2015, rarely gains attention for public health successes. One student reflected that 'the Rwandan success and improvements of community health care workers and decentralization of policies and Brazil's food security programs and cash transfer programs have all exemplified unique models that deconstruct and address social inequities that lead to better health'.

Beyond case studies, course objectives emphasized global health solutions that integrate political processes and 'out of the box' remedies to global health problems, using creative media and techniques. Capstone projects and presentations gave students an opportunity to pick a topic of their choice and propose a way to address the problem. Students chose to carry out group projects on the opioid crisis, indigenous youth mental health, indigenous women's health, international students' mental health, breastfeeding, and refugee health. As mentioned above, the group project on breastfeeding analysed, amongst other topics, the sexualization of women's bodies, negative social perceptions of breastfeeding in public, and profiteering interests of baby formula companies. The students created an Instagram account with images that positively portrayed women and babies bonding, cuddling and feeding. These projects constituted a significant portion of their work, and thus they developed a deeper understanding of the issues and their political nuances.

Many students had taken courses on comparative politics, political theory, scientific political analysis, Canadian politics, global politics, and other courses that solidified their political worldview. This course was thus scaffolded on strong foundations of political theory. While one course was not able to alter students' pre-existing scepticism about politics in general, many developed a sense of agency and optimism for a healthier society.

At the end of the course, we invited students to reflect on their sense of optimism about the possibilities of resolving global health problems (5-point Likert scale; 1 = Not hopeful at all, 5 = Very hopeful); the median response was 4 (hopeful). Half of the students reported that this perception had changed since the start of the term and one student noted that 'perhaps I feel more solidified in my answer after taking this class and interacting with all these passionate people... I also think that many of the successful case studies we learned about in this class made me all the more hopeful!' Others held a more sceptical view, summarized here: 'ultimately I think that humanity is innately selfish and those in power will want to keep it that way' and that society hinges on the powerful role of financial capital: 'people are becoming more polarized than ever, and the issues we talk about fall back to one thing: money'.

Students came into the course with sophisticated understandings of wealth inequalities. From this foundation in political studies, many of them had specialized

in political forces related to the environment, migration, peace and conflict, elections, and other topics. With analyses of underlying political forces, this course carpentered an introduction to the world of public health politics. The definition of health, the social determinants of health, public health solutions and the overarching theme of optimism, and possibilities for better health girded our 'House of Health' in Fig. 36.5.

With a solid foundation of the social determinants of health, students were able to build their own houses of health. Each student's 'House of Health' was then nuanced, with different features of the house, i.e., windows and doors, drawn from their unique experiences and interests. For some students, a new understanding of reproduction and childbearing was one of the most beneficial learnings of the course. For others, taking their passion for environmentalism and constructing a 'House of Health' on top of that helped them to see the links between health and the environment. The students' backgrounds thus predisposed them to conceptually grasping the theme of the course: *global public health is politics writ large*.

Andragogical Approach

The other unanticipated, recurrent theme in student feedback about this course was the andragogical approach, which included the use of participatory and active teaching methods and the respectful nature of their relationship with their professor. This took up a large portion of the student course evaluations and is related to the theoretical aspects of teaching mentioned above.

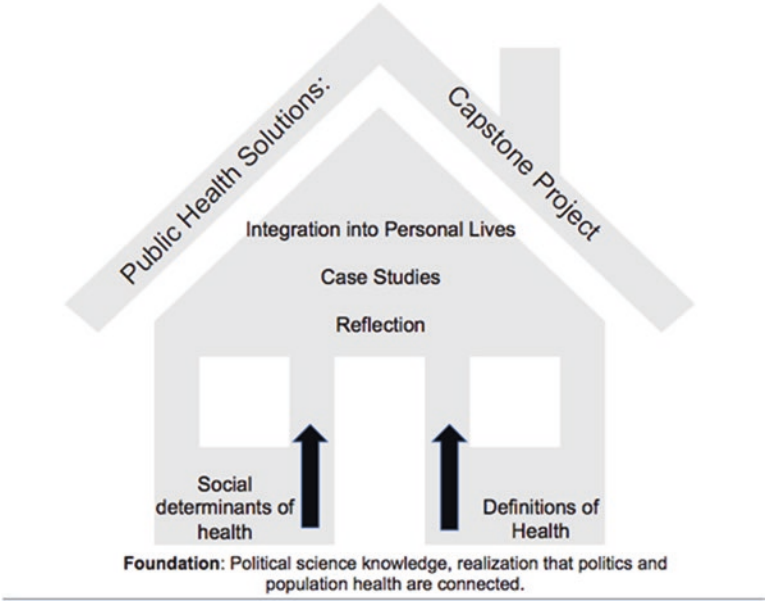

Fig. 36.5 Building a 'House of Health' for students of political science

Impact of Carrying out a Scholarship of Teaching and Learning (SoTL) Study

There were monumental impacts on the faculty member (Shroff) of this course. The feedback from students, both in class and from the evaluation surveys have greatly informed her ongoing teaching practices. The inquiry built into the SoTL process, systematized and comprehensive, was unlike other teaching reflections. A team of experts analysed the impact of the course making the findings more robust and prompted deeper contemplation. These considerations had long lasting implications for future courses.

Previously, her notion of teaching in a university classroom rested upon one of the three domains in education – the cognitive. Now she blends the affect and psychomotor domains of education into all her courses as well. Since the initial course delivery, the second offering of the course incorporated well-being as a central aspect of the student experience. The importance of students' mental well-being in the classroom was a profound lesson for the faculty instructor of the course.

Conclusion

Initially we expected this course to expand students' theoretical frameworks to include public health thereby impacting their perceived career paths or future studies. Through various assessments, students indicated that they felt empowered to enact change in the sphere of public health and saw themselves as change makers within this field. We also learned that some of the most powerful lessons of the course were based on students' personal and interpersonal mental health issues. The classroom became a place where students could engage beyond a purely scholarly and intellectual level. Students felt welcome to bring their whole selves to the classroom.

It appears that one course can have a significant impact on student learning, both in the personal and professional spheres. Atop a foundation of political science theory, each student customized their 'House of Health' according to their academic backgrounds and personal interests.

The course blended many health promotion competencies into projects and course activities. The course was taught by a critical feminist and anti-racism theorist who is inspired by andragogical philosophies of Paulo Freire and others. Students' unprompted appreciation for active, engaging andragogy illustrated the need for more of this kind of teaching in the university setting.

Curriculum Recommendations

We recommend that political science departments offer courses on public health that focus on population health promotion, in addition to politics of the healthcare system, to show the versatility of political science in the field of health studies. As case studies from this course illustrated, elections and government programmes make a huge impact on population health status. One role for political scientists is to work with governments and policy agencies to enact health-related changes.

Accordingly, based on the course premise that *public health is politics writ large*, public health course offerings ought to include a greater focus on political science and specifically on governance. Currently in Canada, university public health departments focus primarily on topics such as epidemiology, biostatistics, occupational and environmental health (Cole, 2013). Some schools teach courses on behaviour-change theories, health economics and other social-science concepts (Watson, 2014). While health policy is covered in some schools, whole courses on political science are uncommon in Canadian schools of public health. The emphasis on the 'hard' sciences is also reflected in health authorities. As public health graduates become more innovative about political models of the social determinants of health, they may be able to gain more traction within healthcare systems. With the infusion of more political theory and practice into public health, we believe that it will be possible to improve health for all with politically savvy, *upstream* solutions that emphasize health promotion and disease prevention (de-Leeuw, E., Clavier, C.,, & Breton, E., 2014).

Generalizability Beyond One Course

Creating conditions for better global health is one of the most important tasks for the modern era. COVID-19's devastation has demonstrated the need for effectively addressing the social determinants of health and creating more just public health structures. The pandemic has also illustrated that politics lies at the heart of public health, reverberating this course's theme. Now, more than ever, many realize the need to integrate many disciplines into public health, particularly those which allow public health measures to be politically savvy. This course's humble effort of bringing political scientists into the public health fold may be replicated at other teaching institutions.

Other courses could also turn students' attention to solving global public health problems. Student agency would thus be encouraged. Many university courses teach students to be critical thinkers. They become adept at critiquing unjust social structures. Students in this political science course had spent their entire undergraduate years learning how to write essays and speak in a critical fashion about

many facets of the contemporary political world. Many spoke about the futility of efforts to create a more just world. This was a serious concern.

> The more students work at storing the deposits entrusted to them, the less they develop the critical consciousness which would result from their intervention in the world as transformers of that world. The more completely they accept the passive role imposed on them, the more they tend simply to adapt to the world as it is and to the fragmented view of reality deposited in them. (Freire, 1973, p. 129)

It would appear that Freire was writing about many modern-day Canadian university students. After spending four to five years in an undergraduate programme studying politics, students often do not feel motivated or equipped to improve the world. We can change this by imbuing ideas that the students are powerful agents and can make our world healthier, for public health metrics are proxies for a more just world.

> What the educator does in teaching is make it possible for the students to become themselves (Horton & Freire, 1990, p. 181)

Self-actualized students will start with their own health. They will seek out means to be healthy – mentally, physically and spiritually. They will then, hopefully, turn to the benevolent vocation of creating conditions for better health for all. The invocation of Health for All, a world cry to the nations of the world at Alma Ata in 1974, has yet to be realized. The UN Millennium Development Goals of 2015 and the Sustainable Development Goals of 2030 embrace similar values. The world is marching forwards towards better health in many measures (and yet marching backwards in others). With a young generation that feels rooted in who they are, comfortable in their own skins, deeply and profoundly loving themselves, the future is in capable hands.

Public health, as a discipline, considers itself to be an all-encompassing arena within which virtually all other disciplines fit. Political science, engineering, mathematics and many other seemingly unrelated fields can have a significant impact on improving community health status, as illustrated by this student's ideas:

> I feel that every problem or issue we face in our world is linked to health. In considering health, we have to think about our social, political, economic environment and vice versa.

Bringing politics into the public health sector will help break down the division between these two fields and help with 'building the house of health promotion upon a foundation of Political Science'.

Future Directions

The Department of Political Science at UBC is over one hundred years old. This was the first course which presented Political Science students with the concepts of Social Determinants of Health. The positive feedback and experiences from this course suggest it would be impactful to have additional political science courses

begin to engage with public health, and vice versa. Since this course has been delivered, numerous students have gone on to pursue careers or further degrees in the area of public health. One student's master's thesis on the opioid crisis, for instance, was a direct continuation of their project in this course. This was the first and only course most of them had taken on the topic but still led to such engagement as for students to pursue the topic beyond the course.

To further our understanding of this particular course and its long-term impacts, a longitudinal study with this cohort at one year and five years post-course would amplify the lessons in this chapter. Another series of studies could explore the important confluence of health and politics for students in political science and students in public health. There have been many calls for more interdisciplinary education. This paper adds to this chorus. Courses that blend political science and public health have the potential to construct a healthier world for all.

Table 36.1 brings our reflection on the six triggering questions suggested by the editors.

Table 36.1 Authors´ reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	As Canadians we are aligned with concepts in the Ottawa Charter which discuss the process of enabling people to increase control over, and to improve, their health. We believe that the social determinants of health, particularly social equity and widespread income distribution are key elements of creating better health for all. Health promotion is a positive, upstream concept that embraces the notion of physical, mental and social well-being.
What is the institutional and political context of your experience (participants, professions and courses involved, duration, and frequency of activities)?	The lead author, Dr. Farah Shroff, has been engaged in health promotion for many years, as an educator, researcher and social justice promoter. She is a member of the People's Health Movement in Canada and strives for Health for All globally. Her passions include feminist anti-racism work to uplift the lives of women who are racialized and from the Global South. To this end, she founded Maternal and Infant Health Canada (maa.med.ubc.ca), a global health promotion collaborative that seeks to improve the lives of women, children, communities and the environment through research, education and innovation. The main innovation is integrative health practices/traditional evidence-based health care systems. Dr. Shroff is a faculty member in the Department of Family Practice and School of Population and Public Health at UBC. In the academic year 2021–2022, she is a Takemi Fellow in International Health at the Harvard School of Public Health.
Which theories and methodologies are used in the teaching-learning process?	Freirian concepts of praxis (action/reflection), combining dialogue with action, are key theoretical foundations to our health promotion andragogy. The chapter discusses various theories related to teaching health promotion, such as the importance of ecosocial theories, interdisciplinarity, and multisectoralism.

(continued)

Table 36.1 (continued)

Questions	Take-home messages
What forms of assessment are applied, results achieved, and challenges faced?	This paper assesses a novel course on health promotion, the first of its kind at the University of British Columbia's department of Political Science. We assessed student perceptions of their own agency, definitions of health, social determinants of health and other topics through quantitative and qualitative techniques. Specifically, students were sent a pre-survey, midterm survey and post-term survey. In terms of student learning during the course, we applied journaling, group projects, small written projects, peer marking, two stage quizzes and other such innovative forms of assessment.
Which principles, pillars, competencies, or approaches to Health Promotion do you base your plan of teaching and learning?	Course planning and teaching are based on all the five pillars of health promotion: (1) A broad and positive health concept; (2) Participation and involvement; (3) Action and action competence; (4) A settings perspective, and (5) Equity in health. The three pillars of health promotion, protection, promotion, and prevention, are also foundation to my teaching approach. Course objectives aligned well with numerous Health Promotion Competencies, based on the Pan-Canadian Health Promoter Competencies and Glossary (2015).
What others could learn with your experience? What is localized and what is 'generalizable'?	We hope that others will reach out to social science departments to teach health promotion in their universities. We also hope that health promotion courses will integrate concepts of political science. This is generalizable across the globe. The local aspects of our chapter are rooted in our students' personal experiences with the course as they are expressed in the qualitative elements of the chapter. The chapter includes a section on generalizable aspects of this course.

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Part VI
Health Promotion as a Transformational Practice

Chapter 37
Introduction to Part VI: Health Promotion as a Transformational Practice

Ana Claudia Camargo Gonçalves Germani

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In the researches in health disparities, there are a discussion about translational, transformational, and transdisciplinary approaches. The focus on the transformational one is based on the innovation and testing of new ideas regardless of anticipated risk (Dankwa-Mullan et al., 2010). What if we adopt this sort of discoveries and developments in health promotion educational field?

How does health promotion education advance in the twenty-first century?

Especially with the overwhelming impact of the pandemic caused by the SARS-CoV-2 virus, being transformative and embracing the complexity are essential to visioning the future of health promotion (HP) (Kickbusch, 2021). Moreover, in the decade of actions toward Sustainable Development Goals (SDG), it is essential for educators to think about and be aware of opportunities and get inspiration from new narratives about HP teaching and learning.

The purpose of this section is to highlight some transformational contributions, which include connections and innovations from all over the world. Importantly, transformational HP teaching and learning practices build on creativity and collective effort. We invite the readers to bear in mind: what kind of transformation? for whom? For which purpose?

This section includes six chapters. Two of them are describing critical reflection on theory in combination with thoughtful discussion: an overview over the last 30 years of a distance-learning module at the Open University that discusses the incorporation of antioppressive practices (Chap. 39) and the Health Change Lab, an experiential education program to explore ethical dimensions to be considered in community-engaged HP pedagogy (Chap. 41). Chapter 40 puts Portugal, Mexico, and Brazil together to highlight examples of educational opportunities involving

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social participation, interculturality, and popular education, and Chap. 43 describes a new initiative, which is a consortium of Brazilian HP graduate programs. Finally, two chapters outline examples of interactive tools to guide the process of transformative change and HP rethinking: The Circle of Health (Chap. 38) and a web platform named "Health Promotion in the Region of the Americas" (Chap. 42).

They include considerations on HP teaching activities for undergraduate (Chap. 41), graduate (Chap. 43), and continuous education (Chap. 40). The observations made in local (Chap. 41), regional (Chaps. 42 and 43), and global (Chap. 39) initiatives illustrate innovative approaches in HP teaching and learning.

Local and regional examples that make it possible to draw a parallel with the 2030 Agenda, acting regionally or widespread, transforming actions from the bottom up.

The section gathers consolidated strategies, as an overview of 30 years, and brand-new ones. Pursuing and achieving sustainable health promotion teaching and learning could be truly transformative.

Lessons about the collaboration process take shape in Chaps. 38, 40, 42, and 43. The initiatives described here foster the empowerment of different sorts of communities, including but extrapolating academic settings. Each chapter reaffirms the focus on equity and ethical HP in a peculiar way.

Once HP matters to the COVID-19 pandemic, and vice versa (Van den Broucke, 2020), the rapid emergence of the global pandemic (with probable animal origin) added new pressure to think about and propose integration and innovations HP teaching and learning practices based on the One Health concept. Even if not explicitly mentioned in the chapters, health promotion educators must be attentive to complex interconnections between human, animals, health, and the environment (Gallagher et al., 2021).

Ultimately, this section shows some "untested feasibility." This expression came from Paulo Freire's works regarding praxis, project, futurity, dream, utopia, hope, and, mainly, the sense of collective project (Paro et al., 2019). According to him, writing down, reading, and reflecting about these issues can nurture permanent educational practices.

Turning the transformational concept into action, reducing the gap between theory and praxis, and sharing these examples, we hope to cultivate advances in HP education in the twenty-first century.

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Chapter 38
The Circle of Health©: An Interactive Tool to Guide the Process of Transformative Change and Rethinking Health Promotion

Patsy Beattie-Huggan

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Introduction

This chapter is being written during a global pandemic—a critical time in society's understanding of the interconnection between physical, emotional, mental, and spiritual health, community, and the economy. During 2020–2021, society has acknowledged many truths in coping with the pandemic. Fear about the spread of the COVID-19 virus has prompted lockdowns to prepare and safeguard our health systems; however, the social and economic impacts of social isolation have created an acute awareness of widespread inequities, the importance of mental health, and the need for a more holistic approach to managing health challenges. The COVID-19 pandemic has brought public health and the social determinants of health into the general lexicon. In this context, there is a need and a public demand for holistic

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practices and policies to manage the present and the future. This has led us to acknowledge that health promotion is critical for leading change.

While current leaders face these challenges, new graduates will soon be the human resources of public and private sectors. How do postsecondary education systems prepare future practitioners to address the challenges posed by these turbulent times? How can decision makers be equipped to invest in health promotion to address the visible societal inequities?

There is momentum to build back better after the pandemic. There is both evidence and opportunity to influence transformative change to a healthier society that values all elements of health. In writing this chapter, I will elaborate on why the Circle of Health is an ideal tool for this moment in time, and how the story of the Circle validates its utility and adaptability. This chapter will outline my experience in the development and dissemination of the Circle of Health, the context in which it was developed and its current relevance today. I will also discuss the transformative impact I have witnessed in facilitating the Circle of Health and offer suggestions to facilitators and teachers who wish to use it in their work.

To quote Mi'kmaw Elder Albert Marshall, from Unama'ki-Cape Breton, Nova Scotia (Interview December 2020), "knowledge is alive physically and spiritually and it is a privilege to be a conduit of it – you were gifted with the Circle of Health because you noticed it." It is my privilege and honor to share this gift.

Background

Following World War II, there was an increased public demand for health services as an investment in postwar recovery. However, as publicly funded health systems developed, governments become increasingly concerned about the gap between high health care costs and positive health outcomes. The first comprehensive government effort to reflect on health status and its determinants was documented in a Canadian document, A New Perspective on the Health of Canadians (Lalonde, 1981), and was internationally acclaimed as a pioneer document in health promotion. During the next decade, additional documents such as the Alma Ata Declaration (WHO, 1978) were indicators of a growing global interest in reframing how we think about and understand health. In 1986, Canada hosted the first International Conference on Health Promotion, and the Ottawa Charter for Health Promotion was launched (WHO, 1986). The Charter identified that underlying conditions for health cannot be ensured by the traditional health system alone but must involve coordinated action by many partners, both government and nongovernment. This contribution to global health promotion was received with enthusiasm and continues to serve as a guidepost for health promotion throughout the world.

In the early 1990s, policy makers on Prince Edward Island (PEI), Canada, embarked on a new policy direction based on a population health approach, embracing principles of health promotion and primary health care as set out by the Ottawa Charter (WHO, 1986) and Alma Ata Declaration (WHO, 1978). A restructured

health system brought together many disciplines including: public health, hospital settings, social services, housing and justice, each with their own frameworks and approaches to health and social care. Although the policy document *"Partnerships for Better Health,"* defined health as a "resource for everyday living" (WHO, 1986), diverse understandings and expectations of health promotion made it difficult to prioritize and assign resources. This health delivery structure was the source of much innovation and drew national and international attention, but it was short lived. In 1996, soon after the launch of the Circle of Health, a provincial election resulted in a change in political ideology and the structure was dismantled, returned to a more traditional health system organization.

While there have been pockets of system innovation such as in PEI, 35 years after the Ottawa Charter was launched, health systems and governments have still not prioritized health promotion to its fullest potential. Professionals and policy makers continue to respond to community pressure to meet crisis demands, with funding allocated to health care treatments and medical services without corresponding efforts to address the factors that contribute to poor health. In addition, many professions are still influenced by independent models of health and social care promoted by their specific discipline. The knowledge, skills, and opportunities for intersectoral collaboration on health determinants are fragmented. These policy and practice challenges make the wide-scale implementation needed for health promotion daunting.

It is of note that the Shanghai Declaration (WHO, 2016) identifies a gap in our momentum for health promotion when it comes to translational strategies. This author proposes that the Circle of Health could fill this gap. The Circle of Health is a translational tool for health promotion that is already used worldwide. It seamlessly integrates many health promotion concepts, as well as integrating many societal values, the Ottawa Charter, determinants of health and the Indigenous medicine wheel. It has been validated by multiple stakeholders and demonstrates a holistic approach to areas such as culture and literacy. It helps to translate concepts to real interventions and prompts the discovery of innovative solutions. There is now a window of opportunity to utilize this tool to its full potential as we resolve to build back better from the COVID-19 pandemic.

The Story of the Circle of Health

At the time of the development of the Circle of Health in 1995, I was in the position of Director of Community Development and Health Promotion for the PEI Health and Community Services Agency, and part of a team providing leadership on new policy direction. Given the interdisciplinary nature of the organization, it was thought that reaching consensus on a framework for health promotion would facilitate a shared understanding of the concepts outlined in the policy documents that were guiding the change. It was in this climate that the Circle of Health was developed.

The story of its development is valuable for those becoming acquainted with the Circle of Health. The story resonates with global and reflective learners and for those with academic backgrounds. It validates the Circle of Health as a well-tested tool that was built on sound methods, shared leadership and a successful partnership.

- *I loved hearing the history as it really helped me understand the reason for the Circle of Health and how collaborative the making of it really was. (COH workshop participant)*
- *It is as if you used the Circle to create the Circle (COH workshop participant)*

This story is written through my eyes in the role I played at the time and includes reflections particular to my experience. To meet the challenge I faced in promoting an organizational shift to a health promotion philosophy, I drew on my experience as a nurse educator, where I had learned that it was good practice to begin with a conceptual framework to ground the direction of change. This approach is based on the belief that when people move from having many pictures in their mind to having one common vision, they have a sense of where they fit and where they are going. To validate this approach, I consulted with Irv Rootman, Director of the University of Toronto Health Promotion Research Centre and Tariq Bhatti, Director of Health Promotion Development for Health Canada. I also consulted with Leslie Boydell, a colleague in Northern Ireland. As a key public health leader in that country, she was dealing with similar challenges—how to shift community and health system thinking to a health promotion philosophy. With outside expertise and partners within the PEI health system and community organizations engaged, our team reached out to the broader community. This began the partnership that mobilized development of the Circle of Health. (Health and Welfare Canada, 1986)

To reach consensus on the need for a framework, representatives of the PEI Health and Community Services System, Health Canada and three community partners (PEI Women's Network, Community Health Promotion Atlantic, and NB-PEI Public Health Association) hosted a forum *Mapping Health Promotion in PEI* in November 1995 with sponsorship from the Canadian Public Health Association and the Atlantic Health Promotion Research Centre. Over 80 stakeholders of the health system, community and academic settings participated in a one-day process answering the question—"*What does health promotion mean to you?"* This theoretical question guided the process and generated creativity, engagement and the conclusion that like a blueprint for building a house, a framework was necessary for developing a health promotion strategy for PEI—one in which everyone could feel represented.

The next day, 12 individuals who attended the previous day's consultation engaged in a session facilitated by Irv Rootman and Larry Hershfield from the Centre for Health Promotion, University of Toronto. Sensitive to the direction provided by the Forum, this group defined a threefold purpose to guide selection of a framework:

- to promote shared understanding of health promotion,
- to assist people in locating links, relationships, and contributions in health promotion work, and

- to provide direction for strategic planning for health promotion.

Existing health promotion frameworks, such as the Ottawa Charter (WHO, 1986) and Health for All (WHO, 1978), were reviewed, and it was concluded that none of these frameworks met all expectations, which included: achieving the aforementioned purpose, explicitly including the values identified in the Forum, and achieving this group's vision of having a hand-held framework that could be used by policy makers, academics, and community. The group decided that the best solution was to undertake the challenge of creating a unique framework.

Of particular influence in this process was Bhatti and Hamilton's Population Health Promotion Model (Hamilton & Bhatti, 1996) which integrated the Ottawa Charter, determinants of health and social theory visually in a cube. It was in draft form at the time and did not have a values platform; therefore, time was invested in a "right brain" process to develop a design. Small groups began drawing, and one group, enthused by the visual of the compass rose in the wallpaper on a nearby wall, visualized a means of layering the four elements to integrate them in one moveable framework (Fig. 38.1). With the compass rose serving as the inspiration for the first design and prototype, a health promotion framework for PEI evolved. This was well beyond initial expectations of adopting an existing framework, and resulted in bringing together the elements of many frameworks into one creative visual. For those who recount that process, it was a powerful, synchronistic and spiritual moment.

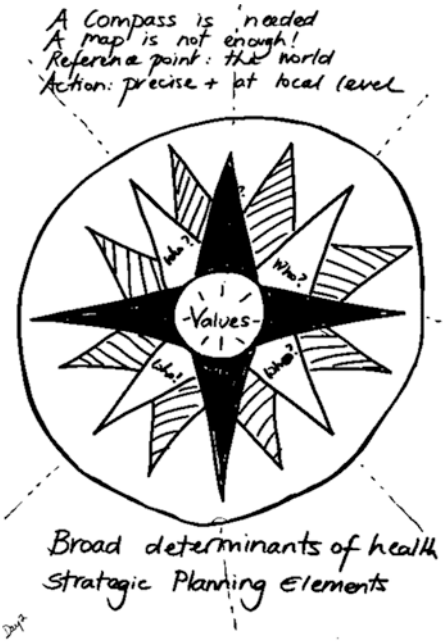

Fig. 38.1 A compass rose served as inspiration for the first framework. (Circle of Health Background Document, 1996)

Validation

The flipchart drawing was sent to a graphic artist who created the first prototype (Fig. 38.2). The validation process that followed involved five focus groups moderated by Steve McQuaid, Community Health Promotion Atlantic, and analyzed by Jean Doherty, Marketing and Communications Coordinator, PEI Health and Community Services Agency. The prototype was tested for concept and design, and the outcome was an overwhelming affirmation of the framework and refinement of the prototype design.

While some people thought the vocabulary on the Circle of Health was too complex for community use, People First, an organization advocating for people with intellectual disabilities, provided a key message: *"Don't change the words – teach us what they mean."* As a result, a plain language learning guide was developed. The PEI Literacy Alliance adjusted the font to make for easier reading. Self-help groups recommended that the visual of the Indigenous medicine wheel be added to the center of the framework, to represent the holistic nature health and the balance they strived for. This addition was affirmed though conversations with Mi'kmaq elders

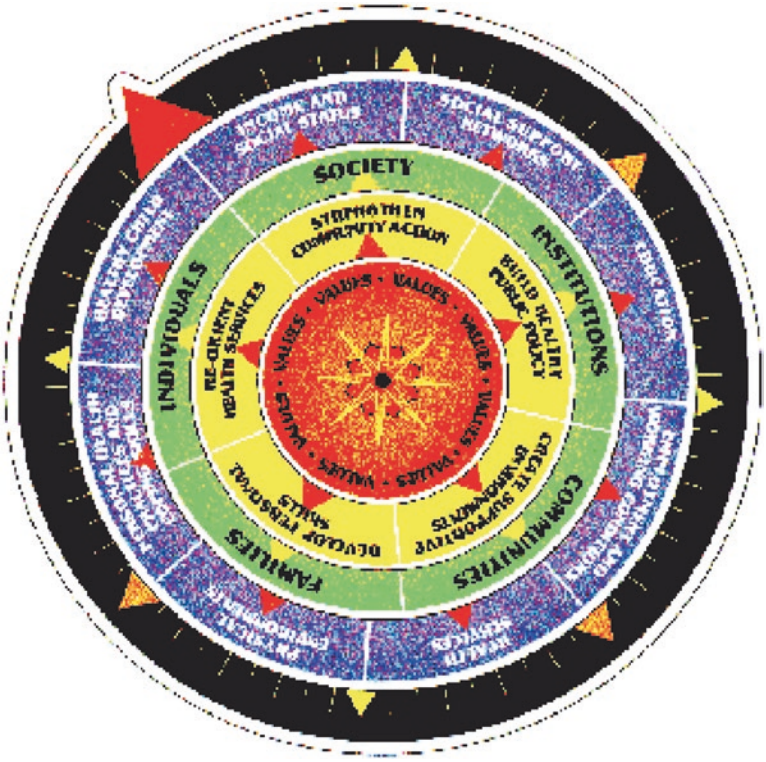

Fig. 38.2 A graphic artist created the first prototype—a compass with a multilayered moveable design. (Circle of Health Background Document, 1996)

and the framework again evolved. At the time of its development, the Circle of Health did not have a name. But as the story and the design were shared and validated, the title "Circle of Health" was born.

Launching the Circle of Health

The Circle of Health (Fig. 38.3) was launched as a moveable card stock tool with rings that could be aligned for exploration of the concepts, in June 1996 at a conference hosted by the PEI Women's Network. Copyright was assigned to the PEI Health and Community Services Agency, Government of PEI.

Fig. 38.3 Circle of Health© PEI Health and Community Services Agency (1996)

The final version of the Circle of Health provides a view "at a glance" of what we know about health promotion. It is both a framework and a tool. Each ring of the Circle of Health represents a body of knowledge and an element of the planning process. The orange ring with the Indigenous medicine wheel represents holistic health; yellow ring the Ottawa Charter (how); green ring population groups as referenced in social theory (who); blue ring determinants of health/population health (what); and purple ring values and ethics in our society (why). The Circle of Health can be entered at any point, and by systematically addressing each element there is movement toward the center where there is integration and wholeness for the individual, family, community, system, or society (The Quaich Inc., 2011).

Often referred to as "the framework of the people" (Beattie-Huggan & Mitchell, 2005), the Circle of Health relies on different visual analogue approaches like its multicolored, moveable rings and plain language. It is designed to overcome barriers of low literacy, so it can be used by nonacademics and those with lower literacy levels. It is structured to assist in a "health in all settings" approach, encouraging users to look at health as a facet of all programs and sectors in a society. The tangible qualities of the Circle of Health engage the varieties of learning, processing and communicating styles.

As discussed later in this chapter, the Circle has been used successfully across geographical and cultural contexts, demonstrating its value in advancing health promotion. As an integrated framework, the Circle of Health provides a systematic way to integrate values, Indigenous wisdom, and determinants of health and other theories at many levels, e.g., "two-eyed seeing" (McKivett et al., 2019). It is the integration of various different frameworks and worldviews allows for heightened knowledge sharing and a sensitivity to different cultural backgrounds.

Dissemination

While the Circle of Health had early momentum on PEI, the path to local uptake was not without challenges. In November 1996, there was a provincial election and government change. Health reform policy documents did not reflect the policy direction of the new government, and many government employees were no longer comfortable with publicly promoting the Circle of Health. From this point forward, the uptake of the Circle of Health was driven by individual champions within and outside of PEI.

While dissemination within PEI was slowing down, there were increasing requests for the Circle of Health outside of PEI, and demand for the "Circle" grew. A questionnaire sent to 108 people in 10 Canadian provinces and 7 countries known to use the Circle of Health found that it was being used by researchers, educators, and practitioners in a variety of settings (Mitchell, 1997). While ratings of design and utility were positive, what was unclear was *how* people were using it. In 1998, qualitative data were gathered through thematic analysis of stories shared in a Virtual Conference, "*Sharing the Circle – Telling the Story*" (Smith, 2000). This

conference adapted the story dialogue method (Labonte & Feather, 1996) for online facilitation and featured stories of international users of the Circle of Health. Transcripts were analyzed for themes, and it was found that the Circle of Health appealed to a wide range of learning styles and was being applied creatively by different users; but the design was also a barrier as it forged a divide between practical and conceptual thinkers. It was clear that for broad uptake, facilitation was required.

My Journey with the Circle of Health

Health promotion is about empowerment; empowerment is about change. Change requires a champion (Thompson et al., 2006). I am often introduced in this role, although being described as a catalyst suits me much better, as my work builds on that of many who came before me and around me.

In 1998, influenced by the restructuring of the health system, I left government and founded The Quaich Inc., a health promotion consulting company. In this new enterprise, I continued my passion for health promotion. I realized that copies of the Circle of Health published in 1996 would soon be depleted. There were no funds for republishing or government staff available to devote to promoting the framework. In 2001, the Government of PEI signed a contract assigning Quaich Inc. distribution and marketing rights, while maintaining the government's intellectual property rights to the Circle of Health. I soon launched into action with ideas to get this tool out to the people who need it most for policy development and implementation, collaborating with others to develop training materials that could bring this innovative framework around the world.

To understand my commitment to the Circle of Health, it is important to reflect on the collective energy and the shared spiritual moments of creative breakthrough involved in its development. From this collective energy has come a belief that to "enable people to take control over, and to improve their health" (WHO, 1986), it is important that we discover and adopt sound processes and evidence-based knowledge translation tools that build on the Ottawa Charter, Indigenous world views and determinants of health. We need tools that are easily understood and applied, that address emerging equity issues, are in the hands of all who need them, and can be used to facilitate knowledge exchange among people with diverse perspectives. Each time I introduce the Circle of Health to others, I believe that it meets these needs.

It is with a passion to convene and build collective capacity that I engage others in applying the Circle of Health. I believe the interface of teacher and learner builds on strengths, incorporates many skills and world views, transforms thinking, and creates innovative solutions to complex structural issues. These underlying beliefs have inspired my work with the Circle of Health, and have taken me on a global

journey of discovery and teaching, finding innovative ways to share what I have learned.

In 2003, I was instrumental in the development of an Advisory Committee for the Atlantic Summer Institute on Healthy and Safe Communities (ASI). The Circle of Health was adopted by ASI as its planning and curriculum framework, and continues to guide the development of programming today.

In 2004, the Quaich called for reviewers, 25 from each country—the UK, USA, Australia, and Canada—to assess the relevancy of the Circle of Health after 8 years (Sato 2004). Relevancy was confirmed, and we also received requests for web-based materials, support, and webinars. The first published article appeared in the International Journal of Health Promotion and Education in 2006 (Mitchell & Beattie-Huggan 2006).

At that time some users were spontaneously developing creative ways of using the Circle of Health to meet local need. In one Canadian province, Newfoundland and Labrador, public health leadership invested in using the Circle of Health to educate health practitioners and the public about health promotion. They devised grant applications requiring completion of a color-coded workplan with colors of the rings of the Circle of Health.

Through international work funded by the Canadian Public Health Association and Canadian International Development Agency, translation was provided and I was invited to share the Circle of Health in workshops in Brazil as part of the Intersectoral Action for Health (AIPS) project (2008) and in Serbia as part of the revitalization of public health postcivil war (2009). My experience in these two very different cultures reinforced the applicability of the Circle of Health across cultures and languages. In each country, facilitation with the Circle fostered collaboration and learning across disciplines, and there was excitement about its potential for guiding transformative system and societal change.

In 2010, a market assessment was conducted in Canada by an external consultant. Interviews were held with customers and experts in public health to explore the markets best served by the Circle of Health. These processes confirmed the unique value of the Circle.

> *Amongst the many frameworks that can be used in public health, the Circle of Health is viewed by those interviewed to be the most comprehensive, adaptable and visual framework they have seen for public health* (Lima Delta Group, 2010).

To celebrate the 15th anniversary of the Circle of Health, a documentary of its history was created, and for the 20th anniversary in 2016 it was celebrated prior to the 6th Global Forum on Health Promotion, hosted for the first time outside Europe, by the Province of PEI. As a pre-Forum event, The Quaich invited five international panelists to share their work with the Circle of Health in a preconference workshop. The message across presentations was that the tool has the power to transform thinking from a medical model to a more holistic, socio-ecological approach to health (The Quaich 2016). When participants of the 6th Global Forum on Health Promotion were asked how the Circle of Health (COH) could add value to implementing the Sustainable Development Goals (SDGs), some comments were:

- *"The COH is a user-friendly accessible tool used by stakeholders across many sectors that do not have a health promotion background; stakeholders apply the Circle of Health and it can help frame conversations in a broader way."*
- *"The COH is a neutral tool that doesn't prioritize one opinion over another but can help bridge understanding to achieve common goals."*

These examples illustrate how the Circle of Health can be used to advance the documented link between health promotion and the SDGs (Harnessing Civic Engagement, 2016; Shanghai Declaration on Promoting Health, 2016).

While developed and validated to meet local needs, this framework has been embraced nationally and internationally and is available in six languages—English, French, Spanish, Portuguese, Serbian, and German. With positive feedback on its relevancy, and requests for support by users, more tools were developed, including: a website (www.circleofhealth.net), online workshops, a facilitator manual, and supplemental knowledge translation tools (while some tools are downloadable at no cost, there are costs for hard copy published documents. Proceeds from product sales contribute to continued knowledge development).

Introducing the Circle of Health to Others

In my global journey with the Circle of Health I have learned a great deal about who can use it, and how. The Circle of Health has been used by undergraduate and graduate students, by researchers and policy makers, by community workers and educators. In Brazil through the AIPS Project, I learned that within a partnership of academics, community centers, and NGOs, the community workers were first to embrace the Circle of Health—and with enthusiasm. In Serbia, public health professionals and teachers enthusiastically adopted the Circle of Health in developing a "new public health" post war, describing it as providing a systematic way to integrate all concepts in health promotion when addressing an issue, and using it as a framework for new medical texts. In Canada, an educator in an Indigenous social work program at Dalhousie University taught me ways to engage active learners in a physical space for a discussion of a case study using hula hoops that matched the color of each ring. An educator at Acadia University shared how she used the Circle of Health as her only textbook in health promotion creating a curriculum that transformed thinking of students; another at Simon Fraser University uses it as the framework for a university change lab and applied it to a Photovoice Project in health literacy (Ardiles et al., 2019). At the Federal University of Goiás in Brazil, nursing students demonstrated how high school students can apply the Circle of Health to plan a suicide prevention program illustrating its wide applications. Numerous strategies developed for tobacco reduction, domestic safety, suicide prevention have been developed. It was included in the EU-funded Mig-HealthCare project and selected for pilot testing for its role to improve health care access for migrants and refugees (Beattie-Huggan et al., 2020; Harsch et al., 2018). All of

these demonstrate a practical application of the Ottawa Charter and holistic approaches to achieving equity and population health. In response to hearing the stories, I serve as a knowledge broker sharing what I learn with others.

In introducing the Circle of Health, I always begin with the story of its development as it allows time to speak to the principles of its development and application, the purpose and the policy documents that are included in each ring and makes clear the theoretical relevance of the Circle of Health.

Once the story is told, I engage participants in reflection and exploring an issue ring by ring. For example, we might look at literacy as a social determinant of health, and go through the Circle of Health using each ring to prompt questions for discussion. In this example, with the center ring I ask what needs we hope to meet by addressing literacy, and in the purple ring I ask why values are important in addressing literacy, why values make a difference and how values impact who you work with. With the green ring I ask who is impacted by low literacy, who is involved now, who could be involved. The blue ring prompts questions about the determinants of health that are involved in promoting literacy. What determinants are impacted by low literacy, what determinants would be impacted if we increased literacy and where are the gaps? Finally, I would ask how we could increase levels of literacy in our communities with reference to the Ottawa Charter on the yellow ring. Which strategies do we need to use in our community? What do we have resources or mandate to address? By visually demonstrating the rings with a stacking tool or through graphics on a PowerPoint slide and discussing one ring at a time, I consider the needs of sequential, visual and intuitive learners. This approach can be applied to many issues of concern such as teen pregnancy, equity of Indigenous peoples or the well-being of migrants (Beattie-Huggan et al., 2020; Harsch et al., 2018).

Following the exploration of an issue, I take time to explore other questions that may be of concern, such as how to use the Circle of Health for partnership development. Where possible I have participants meet in small groups and with special consideration of verbal and active learners ask them to hold the Circle of Health in their hands, moving the rings to introduce themselves in relation to their experience and capacities to address the issue, in this case, literacy. These are but examples. There are many ways to incorporate educational material on partnership development, planning and evaluation and other modalities when teaching health promotion using the Circle of Health.

In the process of seeking ways to share the Circle of Health more effectively, my consulting colleague, Julie Devon Dodd, introduced me to an invaluable resource on the Internet that allows people to assess their learning styles (Felder & Soloman, n.d.): www.webtools.ncsu.edu/learningstyles/.

Applying insights from this site, we developed the following tips for introducing the Circle of Health:

For Global Learners

- Provide the whole story
- Use a banner or large poster of the Circle to provide a whole picture

- Give the purpose of the presentation early—this puts it into perspective
- Use color-coded planning
- Ask participants to create a story themselves

For Active Learners

- Introduce the Circle with a puzzle, game, or fun activity
- Move things: Put the Circle in people's hands
- With color, identify an area on the floor or wall for different rings of the Circle, and have people physically move and talk about that ring

For Reflective Learners

- Ask questions that link to the activity, e.g., What values are important? What is your vision? Who do you work with?
- Provide the folder, learning guide, or web address where people can find more information before the session
- Ask people to reflect for a minute or so before answering a question—write down an idea or two
- Ask questions for each step/ring and give time before asking for responses

For Sequential Learners:

- Create a clear step-by-step agenda (or lesson plan) and share it with the group
- Introduce each ring with an example and use it throughout
- Follow this with a story of how the Circle of Health was used.

These examples do not exclude other methods or take away attention from auditory, verbal and visual learning preferences, but they do open up our minds in considering how to engage students and promote decision-maker investment in health promotion.

Listening to others has helped us realize that in sharing information, we need to consider the needs of the person with whom we are communicating, e.g., learning styles, language, culture, education, gender, socio-economic status, professional training, and more. The more similar the characteristics of the educator and learner, the greater the chance for understanding. Where characteristics of teacher and learner differ, the chance for misunderstanding increases. My task as a knowledge broker and teacher is to communicate so that the learner can understand the message. My task as the learner is to listen and work to understand.

Reaching Beyond Borders: Going Online

Living in PEI, Canada, I knew that if I was to provide support to the many people I met and have yet to meet, I would need to offer workshops via the Internet. Julie Devon Dodd assisted with development of online workshops, and in 2008 we launched the first workshop series structured around the purpose of the Circle of

Health. In 2014, the online workshops were positively evaluated (Rocha & Beattie-Huggan, 2016). In 2016, the idea of training local facilitators for online delivery in Brazil was proposed, but for many reasons, some political, this was not possible. In 2018, the workshops were adapted for an online undergraduate credit course at Furtwangen University, Germany, and since then the course has been offered to 3 cohorts of Health Science students.

In the spring of 2021 as I write this chapter, I have just completed an online workshop with nine participants in six time zones, five countries and from many professions—a primary school teacher, a public health manager, two nursing educators, a curriculum developer for a dentistry program, a community leader of a seniors' center, and two health promoters. Their participation is a testament of the current interest and applicability of the Circle of Health. Their comments include:

- *Circle of Health will be a blueprint for me and I will follow the steps – identifying values, populations, determinants.*
- *I am really appreciating the framework, model, and the language it is offering to explain and be able to relate to co-workers. This is the tool I feel I needed to put some creativity at work. This is such a time to be innovative, and this experience is WOW.*

In my facilitation, I attempt to model the principles on which the Circle of Health is built and share from my global experiences how it can best be applied. In preparation for meeting each group, I ground myself in the center of the Circle of Health, the medicine wheel and value of caring, respect, social justice, balance and sharing in preparation. I structure my presentations and workshops with learning styles in mind. Later I have students and educators take this a step further by assessing their learning styles and developing a presentation for someone with a different learning style as a means of developing insight and new skills in knowledge sharing.

Whether online or in person, conversations focus on values and bring the Ottawa Charter to life each time it is used. New learning technologies are woven through the course, stories of its global application are celebrated and new knowledge and tools are documented for future sharing. The Circle of Health does not provide the learner with solutions—unlike a calorie counter—but it is invaluable as a "mind expander" taking participants to more comprehensive system-based interventions. More stories of its use are on the Circle of Health website at www.circleofhealth.net.

Conclusion

The Circle of Health was developed to meet local needs on PEI. Although it did not have the local impact I initially envisioned, I learned from Indigenous, rural, and urban communities in Atlantic Canada that there are many ways the Circle of Health can be applied in a broader regional context. I also learned that what we created in PEI is transferrable across cultures and contexts, through work in Brazil to address equity issues and work in schools, in Serbia to explore rebuilding public health postwar, and in Germany to foster well-being of migrants. With interpretation

services to overcome language barriers and local health promoters to assist with contextual examples, the framework and approach are transferrable globally.

> *The Circle of Health is an amazing tool for taking the complex concepts of health promotion, determinants of health, and population health and demonstrates how they are interwoven. As a policy maker, I find it extremely difficult to articulate these complex concepts to others, but the Circle of Health serves as a tool for doing this. It drives the concepts of health promotion home and is of huge value for moving people to taking a different and more effective approach to improving health* (Participant, Atlantic Summer Institute 2008).

The Circle of Health gained international attention before the work of "scaling up" health promotion innovation came into vogue. As of 2021, over 10,000 English and 700 copies in other languages of the COH have been distributed, workshops have been held and facilitators trained.

The Circle of Health is the framework for all my work—whether explicitly or implicitly. It is anchored in values, as well as well-grounded research and policy documents such as determinants of health, social theory, the Ottawa Charter and the Indigenous medicine wheel. As the framework is also a planning tool, I draw on skills in strategic and operational planning. In doing so, I reflect on the Circle of Health and promote a color-coded planning template that allows the plan to be communicated in a linear way. I share an assessment tool and logic model template developed by client organizations and shared with permission at no cost. I reference Health Promotion Canada competencies and also work on learning style research from a number of sources. My approach includes sharing knowledge, encouraging reflection, action and innovation; and adapting workshops to varied learning styles.

The Chief Public Health Officer of Canada has recently stressed the need to prioritize health equity in pandemic preparedness, response, and recovery. Communities must consider how they will sustain the momentum for intersectoral action and health equity beyond COVID-19; to ensure foundational pieces are in place to build back better, more inclusively, equitably, and sustainably over the long term.

The Circle of Health can assist in framing the dialogue going forward with current leaders and educators and to prepare students as leaders of the transformative change ahead. That work will require the most creative minds and excellent planning and listening skills. Health promotion can play a key role. Each time I use the Circle of Health, I am inspired by the engagement of others as they discover new solutions to old problems and apply the tool to planning at the individual, family, community, and system level. I treasure the gift I have been given and want to say thanks to you the reader and to everyone who has provided me with support in sharing this "gift" with you.

In concluding this chapter, I encourage all readers to think creatively about how the Circle of Health could be implemented in their respective sectors, communities, and lives. We know that knowledge held within the Circle of Health is beneficial across cultures, languages, and sectors; what we need now is creative knowledge mobilization to disseminate the Circle into the hands of many.

Going forward my best advice is to listen, look for windows of opportunity, convene the people you need, take a leap of faith and trust your intuition. After that it requires a firm belief in your vision, confirmation by believers, and entrepreneurial efforts to make the change we need a reality!

Table 38.1 brings our reflection on the six triggering questions suggested by the editors.

Table 38.1 Authors´ reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	My vision of health promotion is more than an academic definition. It is a dynamic movement that one feels passionately—that empowers, awakens the spirit of caring, respect, and social justice, embraces a holistic approach to health, builds, exchanges, and uses knowledge in its many forms with the goal of creating more inclusive, thriving communities and ultimately society. To generate this energy, I believe it important to have evidence-based knowledge translation tools that build on the Ottawa Charter, are easily understood and applied, address emerging equity issues, and are in the hands of all who need them; tools that can be used to facilitate knowledge exchange among diverse perspectives. The interface of teacher and learner builds on strengths, incorporates many skills and world views, transforms thinking, and creates innovative solutions to complex structural issues. This vision has inspired my work with the Circle of Health.
What is the institutional and political context of your experience (participants, professions and courses involved, duration, and frequency of activities)?	During health reform on Prince Edward Island (PEI), Canada (1993–1994), the policy shift to health promotion was guided by *"Partnerships for Better Health,"* a document grounded in the WHO documents, e.g., Ottawa Charter and Alma Ata Declaration. Government adopted a groundbreaking population health approach for the health system, integrating such services as public health, social services, hospitals, physician services, housing, and justice and thus creating an interdisciplinary structure with many interpretations of policy documents. My role was to foster policy implementation and build partnerships with community. In 1995, a government system–community partnership reached consensus that PEI would benefit by selecting a health promotion framework. The Circle of Health was launched in 1996 with enthusiastic local support and wide national and international interest. An election and subsequent change in provincial government hampered local rollout, but early dissemination outside PEI created global opportunities which continue to expand through my work as an independent consultant.
Which theories and methodologies are used in the teaching-learning process?	The development of the Circle of Health was guided by principles of community development, adult education and qualitative research, using left and right brain perspectives and taking a constructivist approach (Teherani et al. 2015)—Building on the knowledge of the people in the room, which included practitioners, policy makers, community members and academics. I use the same principles and approaches in teaching and facilitating with the circle of health. Viewed as an innovative framework and planning tool, facilitation showcases a systematic way to integrate values, indigenous wisdom, and determinants of health and other theories, e.g., "two-eyed seeing" (McKivett et al. 2019). Whether online or in person, conversations focus on values and bring the Ottawa Charter to life each time it is used. Stories of its global application are celebrated, and new knowledge and tools are documented for future sharing. The Circle of Health is invaluable as a "mind expander" taking participants to more comprehensive system-based interventions.

(continued)

Table 38.1 (continued)

Questions	Take-home messages
What forms of assessment are applied, results achieved, and challenges faced?	Before launching the final design in 1996, the first prototype of the Circle of Health was validated for content and design through 5 focus groups on PEI, and refined with input from marginalized groups and First Nations Elders. In 1997, an evaluation survey was circulated to users in 11 provinces and 20 countries; in 1998 the Story Dialogue Method, adapted for online application, was used to explore how the Circle of Health was being used nationally and internationally. Thematic analysis of the stories demonstrated that the greatest challenge was taking a "complex" framework and making it practical. A facilitator handbook, facilitator training, a website, stacking tools, and online workshops were created to support uptake. In 2014, online workshops were evaluated with positive results regarding the effectiveness of online learning, increased understanding of the Circle of Health and readiness of participants to use it. Each workshop is evaluated for quality improvement.
Which principles, pillars, competencies, or approaches to Health Promotion do you base your plan of teaching and learning?	The Circle of Health is the framework for all my work—whether explicitly or implicitly. It is anchored in values, plus well-grounded research and policy documents such as determinants of health, social theory, the Ottawa Charter and the Indigenous medicine wheel. As the framework is also a planning tool, I draw on skills in strategic and operational planning. In doing so, I reflect on the Circle of Health and promote a color-coded planning template that allows the plan to be communicated in a linear way. As evaluation of health promotion programs is important, I share an assessment tool and logic model template developed by client organizations and shared with permission. I reference Health Promotion Canada competencies and also work on learning style research from a number of sources. My approach includes sharing knowledge, encouraging reflection, action and innovation; and adapting workshops to varied learning styles.
What others could learn with your experience? What is localized and what is "generalizable"?	The Circle of Health was built to meet local needs on PEI. Although it did not materialize as I envisioned, I learned from Indigenous, rural, and urban communities in Atlantic Canada that there are many ways the Circle of Health can be applied in a broader regional context. I also learned that what we created in PEI is transferrable across cultures and contexts, through work in Brazil to address equity issues, in Serbia to explore rebuilding public health postwar, and in Germany to help migrants. While interpretation services overcome language barriers and local health promoters assist with contextual examples, the framework and approach are transferrable. So my best advice is to listen, look for windows of opportunity, convene the people you need, take a leap of faith and trust your intuition. After that it requires a firm belief in your vision, believers, and entrepreneurial efforts to make it a reality!

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Chapter 39
Challenging Oppression in Health Promotion and Developing an Intersectional Framework for Health Promotion in Teaching Health Promotion Through a Distance Learning Module at the Open University

Jenny Douglas

Contents

Contribution

History and Context of Health Promotion in the UK

Teaching and learning in health promotion in the UK has its roots in health education. The role of health education officers developed in the early twentieth century in the UK and was part of the local authority public health departments. In 1927 a Central Council for Health Education was established in the UK to provide information on healthy lifestyles. The Health Education Council was created in England in

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1968 to provide national leadership of health education for England, Wales and Northern Ireland, while in Scotland, the Scottish Health Education Coordinating Committee was established in 1981. The Health Education Council became the Health Education Authority in 1987 and then the Health Development Agency in 2000. The role of the Health Education Council was to advise and promote health education; however, its demise in 1987 was due to the political stance it adopted in relation to health inequalities during the Conservative government. This was a government that did not believe that health inequalities existed and referred only to 'variations in health'. One of the last activities of the Health Education Council (HEC) was to publish the 'Health Divide: Inequalities in Health in the 1980s' (Whitehead, 1987), a review commissioned by the HEC.

One of the projects of the Health Education Council was to develop the academic base of health education through the funding of nine academic lectureships in eight universities through the Health Education Academic Lecturers Scheme (Falk-Whynes, 1991). Six of the nine lecturers appointed were women. Although the project was initially envisaged as a 7-year project to develop Diplomas and Master's degrees in health education, when the Health Education Council became the Health Education Authority in 1997, the 7-year project was reduced to 4 years.

The Health Education Council also supported the Certificate in Health Education through further education colleges and a distant learning module in health education developed by Gaye Heathcote (1987) – the Certificate in Health Education Open Learning project (CHEOLP). The CHEOLP course was organised around five major themes: the nature, function and place of health education; the planning and design of health education activities; managing people and learning: issues of communication; social policy and administration and contemporary issues in health education. I contributed to the contemporary issues in health education writing a section on 'health education in a multicultural society' where I started to introduce concepts about developing anti-racist health education practice (Douglas, 1984).

The Ottawa Charter (WHO, 1986) marked a move from health education to health promotion in the late 1980s and signalled the genesis of health promotion. Public health activists who were dissatisfied with health education with its emphasis on individual behaviour change increasingly used the term 'health promotion' (Catford, 2007). Debates took place around the role of health education and health promotion. In the UK, the late 1980s witnessed the establishment of a professional group called health promotion specialists as health promotion specialists emerged from existing health education officers. In the years following the Ottawa Charter, there was an expansion in health promotion both as a profession and as a field of practice. Health education services had been part of local authorities in the 1970s and became part of area health authorities with the reorganisation in 1974. A further reorganisation in 1984 created district health authorities, and large health education services in some areas were split up and moved into district health authorities (Douglas, 2022). Slowly most health education departments were renamed health promotion departments, although many critics questioned whether there was any change in the type of work that was undertaken by the department and argued that the work was still very much influenced by health education rather than health

promotion principles and approaches (Adams, 1993). There was a move to professionalise health promotion. The majority of the health promotion workforce were women who had come mainly from teaching and health professional backgrounds, and one health promotion specialist interviewed (Douglas, 2015) wondered whether if health promotion had been more male dominated, the field may have been more professionalised – with more highly paid health promotion specialists and established on a more powerful footing.

The new term 'health promotion' needed greater understanding and development, and in 1984 the World Health Organisation (WHO) convened a meeting to define the concepts and principles of health promotion (WHO, 1984). This document formed the basis of the Ottawa Charter for Health Promotion (WHO, 1986) which emerged from the First International Conference on Health Promotion held in Ottawa, Canada, 17–21 November 1986. The Ottawa Charter defined health promotion as a distinct area of public health activity with five key strategies: building public health policy, creating supportive environments, strengthening community action, developing personal skills and reorienting health services. The Ottawa Charter was always conceptualised as guiding the way to the twenty-first century public health, hence subtitled 'towards a new public health'. Public health had become stale and static in the 1980s, and the Ottawa Charter provided a reconceptualisation of ways of carrying out public health utilising a health promotion approach. The underlying focus of the Ottawa Charter and health promotion was on reducing social inequalities in health which could be achieved through social change. It was never envisaged that health promotion and public health would develop as two separate agendas. However, health promotion and public health developed separately with different agendas, different workforces and different academic communities, and as such health promotion perhaps did not gain the political strength that was hoped when the movement started in 1986. The Ottawa Charter was the move towards a new public health; hence, health promotion was always intended to be part of public health. However, as health promotion developed, it became a separate discipline – often in opposition to public health. Health promotion and public health were intertwined and heavily influenced each other. Health promotion approaches have influenced the wider public health agenda, and its success is not always fully acknowledged (e.g. the framework convention on tobacco control, non-communicable diseases, healthy public policy and WHO 2020 Policy).

During the period of the Conservative government (late 1979 to 1997), public health was kept on the agenda by a group of public health activists, many of whom were health promotion specialists. However as public health rose on the political agenda, health promotion and health promotion specialists seemed to disappear. Health promotion specialists are a group of health professionals who have received limited attention in the academic literature on developing the public health workforce. However, specialist health promotion services continued to undergo turmoil and organisational change. With the introduction of the purchaser-provider split in health services in the 1980s, many health promotion departments moved from health authorities to health service trusts – with some in acute trusts and some in community trusts. During the 1990s, the organisational positioning of specialist

health promotion services was still the subject of much debate. A 1993 Society of Health Education/Promotion Specialists (SHEPS) survey indicated that a significant number of health promotion specialist departments felt that their general managers did not understand their role, that they were undervalued and that their resources and budgets were poor. Since the government reforms, health promotion was being viewed more narrowly: health promoters were expected to focus on the health service, especially those in provider trusts, and not so much on alliance working. These findings were reinforced by the work of Nettleton and Burrows (1997a, 1997b), who also found a lack of understanding of the role of health promotion specialists by NHS Trust directors which impeded the development of a more strategic approach to health promotion. In 1994, SHEPS issued a paper laying out roles for health promotion specialists in purchasing and providing in the NHS. This demonstrated not only the broad and comprehensive nature of their role but also their vulnerability as most of the roles were shared with others. A further national survey of specialist health promotion services conducted in 1996 and examining the impact of the NHS reforms indicated that, with the exception of Scotland, there was a shift in the organisational position of specialist health promotion departments from purchaser organisations to NHS provider trusts (Milner & French, 1997). A survey conducted in 1999 (Robertson and MacDonald, 2000) demonstrated that compared to the 1996 national survey, there was a small increase in the number of departments positioned within the Health Authority or Board in England and Scotland while in Wales there was a marked changed following the Welsh Office guidance where all departments moved from an NHS trust to the health authority in 1999.

With the New Labour government in 1997, and the abolition of the purchaser-provider split, specialist health promotion departments were still fragmented despite a renewed policy emphasis on health improvement and addressing inequalities in health. Many health promotion departments were in NHS Trusts; some were part of the public health departments of health authorities. This continued to the 2000s when, in Scotland and Northern Ireland, specialist health promotion services were accountable to Health Boards. In Wales, following the review of health promotion services in 1999, all health promotion departments became part of public health departments but by 2003, health promotion specialists in Wales were located in local healthcare co-operatives. While in England, health promotion specialists were located in a range of organisations – public health departments, acute or community trusts, health action zones, local authorities and primary care groups.

Roots of Health Promotion in Feminist Activism

The genesis of health promotion, arguably, was the Ottawa Charter, and although there were only a few UK women involved, women shaped the focus and principles of the Ottawa Charter. I would argue that not only were women instrumental in the development of health promotion and active at all levels from practice to policy but

also that health promotion itself was a feminist project, developed and guided by feminist principles.

Ilona Kickbusch, one of the key architects of the Ottawa Charter who had a PhD in political science and sociology, attended the Conference on Health Promotion in Ottawa. Ilona was very active in the women's health movement in Germany and was one of the first German women academics to write about women's health in the tradition of 'our bodies ourselves'. After undertaking research on consumer-centred health services and people's participation in health, Ilona went to work for the WHO European office, where the WHO was introducing a new approach to health education – 'health promotion'. Here she was instrumental in developing the WHO European strategy for health promotion and initiating a number of European research projects on women's health leading to the first report on women's health which presented disaggregated data on women's health. Ilona reports that the Ottawa Charter and the development of health promotion were informed by her feminist perspective, not just as an academic but as a member of the women's health movement and her involvement as part of women's self-help groups with the political discussions and political fights (Ilona Kickbusch personal communication, 2015).

Thus, the Ottawa Charter itself was influenced by a feminist perspective. In total, 200 participants attended the Ottawa conference from a range of backgrounds including community projects, local government and research and teaching and were drawn internationally from 38 different countries. In addition to Ilona, a number of other women attended including Meg Stacey, a sociology professor from the University of Warwick, UK; Nancy Milio, University of North Carolina, USA; Rita Stern, Canada; Kathryn Dean, Denmark; Nancy Shosenberg, Canada; and Norma Svenson and Marianne Scruggs, Boston Women's Collective, USA (WHO, Health and Welfare, Canada and Canadian Public Health Association (1986). Norma Svenson was a founding member of the Boston Women's Health Collective – the authors of the groundbreaking book, 'Our Bodies Ourselves' which was to become central to the women's health movement. Norma and Marianne contributed to the final document in the Ottawa Charter to a section about health promotion and birth.

The women's health movement had emerged in the 1960s and 1970s as part of the second wave feminist movement. This movement urged women to take control of their health and their bodies and to make 'the personal, the political'. With a focus on reproductive health, and empowerment, the women's health movement demanded appropriate health services for and by women. At the forefront of this movement was the Boston Women's Collective and their groundbreaking book 'Our Bodies Ourselves', the feminist healthcare handbook. The book 'Our Bodies Ourselves' was published commercially first in 1973 and sold over four million copies (Davis, 2007).

The involvement of women in authoring the Ottawa Charter demonstrates that women were not only involved actively working on the ground in health promotion but that women and feminists influenced public health and health promotion at an international policy level, drawing from their work in the women's health movement. Furthermore, many health promotion specialists had been involved in the women's health movement, the emergent ecological movement, the civil rights

movement and the gay pride movement and brought these approaches to health promotion and the new public health movement.

Developing the 'Promoting Health' Module at the Open University

The Open University course 'Promoting Health: Knowledge and Practice' was first offered as a distance learning course from February 1997 as a 60 credit course as part of an undergraduate degree and also as a stand-alone course. I was involved as a critical reader of the course looking at the inclusion of diversity and an anti-racist pedagogy in the course materials. At the time, I was Director of Health Promotion for Sandwell Health Authority in the West Midlands and one of a handful of Black and minority ethnic heads of health promotion units in the UK. Sandwell is a borough in the West Midlands with an industrial past that has high levels of deprivation and poverty. The population is multiracial with many people from Black, Asian and other minority ethnic groups.

The course was structured around a series of learning guides which directed the students to two co-published course books – 'Promoting Health: Knowledge and Practice' (Katz & Peberdy, 1997) and 'The Challenge of Promoting Health: Exploration and Action' (Jones & Sidell, 1997) and a co-published Reader – Debates and Dilemmas in Promoting Health (Jones & Sidell, 1997; Katz & Peberdy, 1997). I contributed a chapter to the Course Reader 'Developing health promotion strategies with Black and minority ethnic communities which address social inequalities' (Douglas, 1997) and to the course book on 'The Future of Health Promotion' (Douglas et al., 1997). Although only students registered on the course had access to the learning guides and other course resources such as audio and video material, the co-published texts were available to purchase, and many students on other health promotion courses purchased the texts. Chapters in the texts were written by other health promotion academics and the Open University, through the Promoting Health module team and associate lecturers contributed to academic debates about health promotion and to the UK Health Promotion Academics Forum.

In the first 10 years of the course, from February 1997 to 2007, a total of just under 8000 students registered on the course. The vision of the health promotion module was based on the five strategies of the Ottawa Charter and was based on the values of equity, equality and social justice. This chimed with the social justice mission of the Open University. The course took a social determinants approach to health promotion and focused specifically on inequalities in health, recognising that health promotion was an increasingly global enterprise. Sustainability and planetary health were integral to health promotion. The course recognised that health promotion was contested and political in nature and that it was multidisciplinary incorporating social policy, sociology, medicine, epidemiology, psychology and environmental sciences. A range of theories and methodologies including Dahlgren

and Whitehead's social determinants framework and Antonovsky's theories of salutogenesis provided the foundational approach to the course as well as Paulo Friere's critical pedagogy and conscientisation.

The pedagogical approach was to develop and design teaching materials that brought health promotion theory and practice to life through the development of relevant case studies. The case studies were selected from health promotion practice in all four nations and in the emerging and developing Belfast, Glasgow and Liverpool Healthy Cities projects. The teaching strategy was to encourage critical exploration and examination of the case studies presented by the students. By doing this, students could relate health promotion interventions under examination to their own practice and geographical location and recognised that health promotion was contested and political in nature.

The assessment strategy includes a range of formative and summative assessment, based on the activities that public health practitioners would undertake in their day-to-day work including report writing, undertaking an academic literature review and developing health promotion strategies on specific issues. There was continuous assessment through tutor-marked assignments and a final end of module assignment. The tutor-marked assignments are built towards the end of the module assignment. Through monitoring the marking of associate lecturers, the module team were able to ascertain how assessments were interpreted by students, and this was fed back into the design of future assessments. In addition, through academic conduct work, the module team were able to see how some assignments were more susceptible to student plagiarism and hence this fed into the design of assessments to reduce this potential susceptibility.

The courses teaching and learning approaches were guided by principles of health promotion and thus learning started with where the student was in terms of knowledge and understanding, and it built on this by working through the ways that health promotion interventions were designed, developed, implemented and evaluated. The pedagogical focus was on research, policy and practice and used an approach of spiral learning. The module was delivered by a team of associate lecturers, many of whom were working in health promotion practice and academic health promotion. Associate lecturers were supported by the module team of central academics through online forums, online meetings and face-to-face briefings.

The module attracted students from across the UK and also some international students. At first, students were mainly health professionals, but as the module developed, students came from a range of backgrounds including teaching, local authorities and the third sector as well as individual students who were interested in gaining knowledge about health promotion. I joined the course in 1999 as a senior lecturer in health promotion, and my first task was to undertake a midlife review of the course and update the course learning guides, audiovisual materials and course books in line with changes in national health/promotion and public health policies and to reflect political changes and the changes in the public health policies of the devolved nations in the UK. The course continued to be updated to reflect political changes in public health and health promotion until 2007.

With the increasing divergence between health promotion and public health and the shift towards 'public health', the module was renamed 'Promoting Public Health' in 2007/2008. Between 2008 and 2019, there were 4000 students registered on the module. I discussed the gulf between health promotion and public health in my chapter in the new course reader 'Promoting the public health: Continuity and change over two centuries' (Douglas, 2007).

Here I argue:

> There has been keen debate about the boundaries between public health and health promotion. MacDonald (1998:28) has stated that: 'the principles and content of modern health promotion are identical to those of the new public health'. However, as public health has risen up the political agenda, critics have argued that health promotion and health promotion specialists seem to be disappearing. (Scott-Samuel, 2003; Douglas, 2007:15)

Many postgraduate courses in health promotion in this period – mid-2000s – changed the titles of the courses to 'health promotion and public health' or just to 'public health' to reflect the turn towards 'public health' in national policies and strategies across the UK. At the OU the module was renamed 'Promoting public health' to signal the incorporation of health promotion and the new public health to the module. This was not without its dilemmas as the use of the term 'public health promotion' became commonplace. This term conflated the concepts of health promotion and public health, and sometimes the values of equity, equality and social justice that underpin health promotion can become obscured (Tilford et al., 2003). The Promoting Public Health module team continued to contribute to wider academic debates about health promotion and public health, and in November 2006 convened a meeting of the UK Health Promotion Academics Network to mark the 20th anniversary of the Ottawa Charter. Professor Ilona Kickbusch, one of the architects of the Ottawa Charter, gave a keynote address on 'Twenty Years after Ottawa – the next challenges for Health Promotion'. Jane Wills and Jenny Douglas (2008) also co-edited a special issue of Critical Public Health to explore health promotion 20 years after the Ottawa Charter.

In the Promoting Public Health module, teaching and learning were still based on the Ottawa Charter principles and values of health promotion and anti-racist pedagogy. In addition, the module was mapped against the UK Public Health Register competencies for public health practitioners. Many of the students already had professional training as nurses or teachers and undertook the module to gain a Certificate in Promoting Public Health or to assist them in applying to the UK Public Health Register (UKPHR) for practitioner registration.

By 2017 the module was updated again and was presented completely online. In higher education, there is a global and national trend towards using technology to create virtual learning environments. In 'K311 Promoting Public Health', a web-based method, Adobe connect, was used to provide online synchronous and asynchronous tutorial platforms. The challenge this posed was to ensure interactivity and enable students to remain engaged. The further update to the module in 2017 incorporated Kimberle Crenshaw's theory of intersectionality and critical race theory and applied this to health promotion and public health. In developing teaching

and learning approaches in public health, the module progressed from a purely social determinants approach to an intersectional approach. Although the module was mapped against the UK Public Health Register competencies for public health practitioners, and hence had relevance for the UK, the module also took a global perspective, and the principles underlying the module were generalisable to other parts of the world. There were many gains from teaching totally online as all students could access all module texts online and hence could undertake the module wherever they had access to the Internet, but one of the losses was that there were no longer co-published textbooks which were used by other higher education institutions.

Incorporation Anti-oppressive Practice in Teaching Health Promotion

While the Ottawa Charter focused on inequities in health, in the early 1990s, there was very little emphasis on promoting health in Black and minority ethnic communities in the UK. There were increasing Black and minority ethnic communities in cities in the UK and a need to develop appropriate and relevant health promotion programmes and initiatives that address health inequities and disparities which they experienced. In addition, there were relatively few Black and minority health promotion specialists or managers, despite the expanding and developing field of health promotion. Often health promotion programmes that were developed on the health needs of Black and minority ethnic communities focused on only cultural differences rather than the structural inequities that Black and minority ethnic communities faced. It was essential that teaching and learning in health promotion recognised and addressed this. The 'Promoting Health' course addressed this through the series of case studies throughout the course.

From the inception of the 'Promoting Health' course, I have provided consistent critiques of health promotion from a Black perspective (Douglas, 1995; Douglas, 1997) and argued that the discourse of multiculturalism disguises the issues facing black and minority ethnic communities in Europe:

> A failure of the multicultural approach is the lack of acknowledgement of the material causes of ill health in black and minority ethnic communities in relation to poverty, discrimination, poor housing, poor working conditions, employment and racial harassment. All of these areas have been documented but have had little impact on the development of health promotion programmes… It is almost as though by addressing the health promotion needs of black communities from a cultural perspective, issues of inequality were also being dealt with. (Douglas, 1995, p74)

Despite the World Health Organisation's emphasis on addressing inequalities in health in Europe, nowhere in the literature accompanying and supporting the WHO's strategy (Health for All) was any reference made to Black and migrant communities in Europe and the impact of racial discrimination on their health at this time. Thus,

although equity underlies the approach of Health for All, there was no recognition of this in relation to racial discrimination and racism (Douglas, 1997).

Developing an Intersectional Framework for Public Health and Health Promotion

The Ottawa Charter states that:

> Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to make decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members. (Ottawa Charter on Health Promotion, World Health Organisation, 1986

The above quote from the Ottawa Charter for health promotion acknowledges the social context of health. However, health promotion and public health research on health behaviours often ignore the social and cultural contexts of people's lives, and health promotion programmes are sometimes developed that are not culturally or socially relevant to the population they are targeted at. Although health promotion programmes aim to reduce social inequalities, health promotion research, upon which such programmes are based, has often ignored the needs of black and minority ethnic communities. It cannot be assumed that findings from research that has been conducted on health behaviours in predominantly white populations can be extrapolated to other ethnic and cultural groups. In terms of developing effective public health interventions, programmes must be culturally relevant in order to be meaningful.

More recently there has been greater awareness of the importance of developing anti-oppressive practice and an intersectional framework in health promotion. Reid et al. (2012) argued that health promotion and health promotion research were still dominated by biomedical, psychological and behavioural theories. They suggested that health promotion and health promotion research were under- theorised and called for the introduction and development of more critical social theories in health promotion research. Furthermore, they proposed that applying intersectionality theory to health promotion could increase its rigour and applicability to diverse populations and could address inequity more effectively (Douglas, 2019).

Kimberle Crenshaw (1989) coined the term 'intersectionality'. Intersectionality was originally developed as a legal theory (Crenshaw, 1989) and has subsequently been used as an organising category for feminist inquiry in many different disciplinary fields in social sciences and humanities (Lewis, 2013). More recently intersectionality has been applied as a theory to explore inequalities and inequity in health (Hankivsky & Christoffersen, 2008; Hankivsky et al., 2010; Hankivsky, 2012; Bowleg (2012). Building on a Black feminist epistemology and the scholarship of many other black feminists (e.g. Davies, 1981; Collins, 1990), intersectionality theory tries to address the complexity of social life by recognising that individuals

simultaneously occupy multiple social locations. Cho et al. (2013: 792) suggest that the methodological and theoretical foundations of intersectionality can be formalised by building from empirical studies within particular disciplines. This is certainly a possibility within the discipline of health promotion.

An intersectional approach can be distinguished from a social determinants of health approach in health promotion and public health. In a social determinants of health approach, social categories such as 'race', gender and class are additive – e.g. 'race' + gender+ class – but in an intersectional approach, multiple oppressions are intertwined and categories intersect, shape and influence each other such that something new is created and experienced at the intersection of one or more social category. Health promotion and intersectionality both proceed from a social justice position, and power and social justice are integral to an intersectional approach to health promotion.

Heard et al. (2019) argue that health promotion researchers and practitioners can use intersectionality theory to better understand and address health inequalities.

> Intersectionality theory as an epistemological approach recognizes that complex relations between multiple identities and social systems of power shape an individual's experiences. Developing such understandings requires research methodologies in public health that draw out tensions between complex and dynamic social contexts, individual and group identities, and biographies. (Heard et al., 2019: 4)

Teaching and learning in health promotion and public health must incorporate an intersectional pedagogy to equip future health promotion practitioners and researchers to be able address complex health inequities and health challenges in a globalised world. These inequities and challenges have been laid bare in the last 18 months through the COVID-19 pandemic, and intersectional epidemiological approaches are needed to understand the disparities between groups that have been disproportionately impacted by COVID-19 and to ensure that global health inequities do not widen.

Case (2017) proposes that an intersectional pedagogy:

- Conceptualizes intersectionality as a complex of both privileged and oppressed social identities that simultaneously interact to create systemic inequalities, and therefore, alter lived experiences of prejudice and discrimination, privilege and opportunities, and perspectives from particular social locations. Intersectional theory pushes us beyond the additive model as categorical and mutually exclusive;
- Teaches intersectionality across a wide variety of oppressions, including not only gender and race, but also the long list of social identities typically neglected in the curriculum (e.g. sexuality, ability, gender identity, immigrant status);
- Aims to uncover invisible intersections;
- Includes privilege as an essential aspect of learning about intersectional theory;
- Analyses power in teaching about intersectional theory, pushing the boundaries of teaching multiculturalism, diversity, oppression, and discrimination;
- Involves educator personal reflection on intersecting identities, biases, assumptions, and the ways instructor social identity impacts the learning community;
- Encourages student reflection and writing about their own intersecting identities and careful consideration of how these identities shape their own lives, psychology, perceptions, and behaviours;

- Promotes social action to dismantle oppression through student learning that extends beyond the classroom walls via service learning, public education projects, and ally action for social change;
- Values the voices of the marginalised and oppressed by avoiding claims of equal validity awarded to all perspectives and maintaining critical analysis of the ways power and privilege limit individual perspectives and experiences with oppression; and.
- Infuses intersectional studies across the curriculum, including a wide variety of disciplines as well as courses not typically associated with diversity content.

Case, 2017:9)

The above checklist from Case (2017) is particularly relevant in relation to incorporating an intersectional pedagogy to designing and delivering health promotion courses focused on addressing health inequities.

Conclusion

This chapter discusses the development of the 'Promoting Health' course and the 'Promoting Public Health' module at the Open University and argues the case for incorporating an intersectional pedagogy into the teaching of health promotion. Between 1997 and 2019, around 12.000 students in total were registered on the course and module and were involved about learning about health promotion and public health from an anti-racist and intersectional perspective. Furthermore, the chapter gives an overview of the health promotion project and suggests that health promotion developed from the feminist locations of the architects of the Ottawa Charter. The chapter concludes that future health promotion teaching and learning must incorporate an intersectional pedagogy if health promotion practitioners and researchers are to be equipped to tackle health inequalities and inequities through the development of effective, relevant and appropriate health promotion programmes, strategies and policies. It is unfortunate in the UK that the opportunity to establish an Office for Health Promotion in England in 2021 has been superseded by the establishment of an Office for Health Improvement and Disparities, so once more the term 'health promotion' disappears from public policy discourse. At the Open University, we are developing a new Public Health module called 'Public Health: health promotion and health security, that will continue to be based on the principles of the Ottawa Charter and an anti-racist and intersectional health promotion pedagogy.

Acknowledgements The perspectives I have presented in this chapter are based on my own personal reflections; however, they have been shaped by the many health promotion academics, practitioners and researchers I have had the privilege of working with over the last 30 years or so.

Table 39.1 brings our reflection on the six triggering questions suggested by the Editors.

Table 39.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	The vision of health promotion is based on the five strategies of the Ottawa Charter. It takes a social determinants approach to health promotion and focuses specifically on inequalities in health, recognising that health promotion is an increasingly global enterprise. Sustainability and planetary health is integral to health promotion. Health promotion is contested and political in nature. It is multidisciplinary incorporating social policy, sociology, medicine, epidemiology, psychology and environmental sciences. Health promotion draws on a range of theories and methodologies including Dahlgren and Whitehead's social determinants framework and Antonovsky's theories of salutogenesis
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	I have been a senior lecturer in health promotion at the Open University for over 20 years. Prior to this I was a lecturer in health education and health promotion at the University of Birmingham. Before this, I set up and managed the health promotion service in West Birmingham and I was Director of Health Promotion for Sandwell Health Authority. The OU course 'Promoting Health' was first offered annually as a 60 credit undergraduate distance learning course at the Open University from February 1997. From February 1997 to October 2019, approximately 12,000 students enrolled on the module. Students were from across the UK and also some international students. At first, students were mainly health professionals, but as the module developed, students came from a range of backgrounds including teaching, local authorities and the third sector as well as individual students who were interested in gaining knowledge about health promotion
Which theories and methodologies are used in the teaching-learning process?	Our teaching approach is to develop and design teaching materials that bring health promotion theory and practice to life through the development of relevant case studies. The case studies have been selected from health promotion practice in all four nations of the UK. The teaching strategy is to encourage critical exploration and examination of the case studies presented by the students. By doing this, students can relate health promotion interventions under examination to their own practice and geographical location. Health promotion is contested and political in nature. It is multidisciplinary incorporating social policy, sociology, medicine, epidemiology, psychology and environmental sciences. We draw on a range of theories and methodologies including Dahlgren and Whitehead's social determinants framework and Antonovsky's theories of salutogenesis. I draw upon Paulo Friere's critical pedagogy and conscientisation as well as bell hooks theories of education as a practice of freedom. I also apply Kimberle Crenshaw's theory of intersectionality and critical race theory to health promotion

(continued)

Table 39.1 (continued)

Questions	Take-home messages
What forms of assessment are applied, results achieved and challenges faced?	The assessment strategy includes a range of formative and summative assessment, based on the activities that public health practitioners would undertake in their day-to-day work including report writing, undertaking an academic literature review and developing health promotion strategies on specific issues. There is continuous assessment through tutor-marked assignments and a final end of module assignment. The tutor-marked assignments are built towards the end of the module assignment. Through monitoring the marking of associate lecturers, we can ascertain how assessments are interpreted by students, and this is fed back into the design of future assessments. In addition, through academic conduct work, we are able to see how some assignments are more susceptible to student plagiarism, and hence this feeds into the design of assessments
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	Teaching and learning is based on the Ottawa Charter principles of health promotion. The module is mapped against the UK Public Health Register competencies for public health practitioners. Our teaching is guided by principles of health promotion, and it starts where the student is at in terms of knowledge and understanding and it builds on this by working through the ways that health promotion interventions are designed, developed, implemented and evaluated. We do this through a focus on research, policy and practice and we use an approach of spiral learning. The module is delivered by a team of associate lecturers, who are supported by central academics through online forums, online meetings and face-to-face briefings
What others could learn with your experience? What is localised and what is 'generalisable'?	The K311 module is now totally online. In higher education there is a global and national trend towards using technology to create virtual learning environments. In K311 a web-based method, Adobe connect, is used to provide online synchronous and asynchronous tutorial platforms. The challenge this poses is to ensure interactivity and enable students to remain engaged. In developing teaching approaches in public health, we have developed from a social determinants approach to an intersectional approach. Although the module is mapped against the UK Public Health Register competencies for public health practitioners, and hence has relevance for the UK, the module also takes a global perspective and the principles are generalizable. The updated module K310, Public health, health promotion and health security will have a global perspective and will be based on an anti-racist and intersectional pedagogy for health promotion and public health

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Chapter 40
Teaching and Learning Health Promotion Through Social Participation, Interculturality and Popular Education

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Introduction

The teaching and learning process in the field of health promotion involves various epistemological approaches and methodological possibilities. The collective practices in health education, which are part of the experiences being reported in this chapter, form a field of knowledge that combines and integrates both scientific and popular knowledge, aiming at showcasing the leading role and the autonomy of all the agents involved in the learning process (Alves, 2005; Reis, 2006). This axis is an important space within the context of the construction of collective knowledge, made possible through a dialogue between healthcare system users and professionals, with the aim of promoting convergence between the reality of communities and population groups. Due to its complexity, it also involves health management and popular control (Vasconcelos et al., 2009).

According to Oliveira (2005), we can highlight two specific models of approach within the context of educational health practices: the traditional model and the radical model. The first is based on the premises of the biomedical model, which is essentially prescriptive in terms of rules and conduct for preventing diseases and maintaining proper health habits. In contrast, the radical or dialogic model emerges in line with the premises of health promotion, which takes into account the complexity of public health, social reality and the various agents involved. In this sense, the radical model is committed to the horizontalisation of educational actions with healthcare teams and the community, promoting healthcare users' critical awareness as well as their empowerment and decisions in relation to life conduct (Oliveira, 2005).

Given the understanding that the teaching and learning processes in the field of health promotion is potent when adopting tools such as participation, dialogue, shared construction of knowledge and respect for different knowledge and cultures, we propose, in this chapter, the presentation of three experiences related to health promotion teaching-learning: one in Lisbon, Portugal; another one in Puebla, Mexico; and a third one in Porto Alegre, Brazil. The experiences have in common the use of the educational tools described above. As specificities, in addition to the different countries and their respective socioeconomic and cultural realities, we highlight the specific approaches that each experience uses as support.

The experience in Portugal is anchored in a perspective of participatory research. Participatory research advocates that we can acquire in-depth knowledge on something about society life or culture when the researcher gets involved and is committed to what he/she is investigating. The premeditated intention of the established relationship sees others as people who are also the subjects, and not just the objects, of the research (Moretti & Adams, 2011).

As for the experience carried out in Mexico, it is based on the perspective of interculturality, which appears as a recurring topic in debates on cultural diversity in health education, gaining relevance for the affirmation of the rights and alterity of various sociocultural groups (Azevedo & Campos, 2019). Bearing in mind that every debate about education has a political nature (Freire, 1996), the rise of the

term ‘interculturality’ in pedagogical literature corresponds to the democratic transition that occurred in the 1980s and the educational and social policies that followed. According to Candau (2012), interculturality presents a polysemy of meanings, which requires definition and a critical look. The term is used for the recognition and appreciation of various cultures and their affirmation, aiming to understand their specificities.

Lastly, the experience in Brazil presents the teaching and learning processes of health promotion for community health agents, supported by the perspective of the Permanent Education in Health policy. In Brazil, the history of permanent education first appears at the same time as the Brazilian Sanitary Reform movement and followed through which collective health was built in the 1980s (Ceccim, 2005). Thus, permanent education is initially structured in order to turn workers’ education into permanent process, seeing work as an axis of the educational process, a source of knowledge and an object of change which privileges collective and multidisciplinary participation and favours a dynamic construction of new knowledge through investigation, the analytical management of information and the exchange of knowledge and experiences (Haddad et al., 1994).

Below we present the teaching-learning experiences in health promotion carried out in Portugal, Mexico and Brazil.

Training of Community Researchers for the Promotion of Sexual Health in Portugal

The experiences in Portugal that will be described below were developed within participatory research on sexual health promotion and relate to knowledge sharing between project partners and training experiences of community researchers.

Participatory research is a collaborative approach that equitably involves and incorporates the perspectives of researchers, community members, representatives of governmental and non-governmental organisations, healthcare professionals and policymakers in the process of knowledge production (Abma et al., 2019; Dias et al., 2018). Indeed, the collaborative nature of participatory research allows to build a trustful relation between the researchers and community partners that promotes the study’s acceptance among the community, resulting in increased adhesion to the study and better data quality, by obtaining spontaneous and reliable information from participants (Dias et al., 2018; Dias & Gama, 2014; Strauss et al., 2001).

The use of the participatory approach enables the integration of questions prioritised by communities but that are often not considered by researchers. Hence, the engagement of communities in the study design contributes to generating data that are more adequate and relevant for them. This engagement is also valuable in the development and validation of data collection instruments, definition of participants’ recruitment approaches and data collection. By having a deep knowledge of the community’s context, community partners can help researchers identify

locations and social networks for the recruitment of participants and data collection (Dias & Gama, 2014). This is particularly valuable in studies focused on hard-to-reach populations, as these groups might be more reluctant to be approached by researchers or to participate in research (Roura et al., 2021). Finally, and of most importance, the participatory research process contributes to partners' capacity building, empowerment of communities to address their health needs and priorities and an increased sense of responsibility for the project (Dias & Gama, 2014; Ramsden et al., 2010; Roura et al., 2021).

An experience of participatory research that enhanced knowledge sharing between partners and training experiences of community researchers was the HIV biobehavioural surveys conducted with most vulnerable and key populations, as migrants, sex workers (SW) and men who have sex with men (MSM). These researches were based on a partnership between an academic institution and an HIV/AIDS NGO with years of community work experience. It aimed to produce knowledge that contributed to the promotion of sexual health, to reduce HIV infection and to improve access to healthcare among the aforementioned populations. Additionally, it intended to promote capacity building of stakeholders for advocacy and policymaking and to empower communities to develop skills for sexual health promotion. With an intersectoral nature, all the stakeholders interested in and affected by the HIV problem were involved in the research, namely, researchers, health professionals, policymakers, elements of NGOs, community-based organisations (CBOs) and civil society.

For embracing a high and diverse number of potential partners, NGOs and CBOs that worked with migrants, SW and MSM were invited to actively collaborate in the projects. Community Advisory Boards (CABs) were formed comprising social intervention workers, NGO representatives and members of the communities. Regular meetings, workshops and focus groups with the CABs and projects partners were an optimal setting for constructive dialogue that enabled each member to acknowledge others; share knowledge, expertise and resources; debate on foundational perspectives; and expand on further collective new ideas and aspirations for the projects and its components (Dias et al., 2018). This context fostered the deepening of social relationships and mutual trust and the strengthening of resources allocation and paved the way for sustained partnerships throughout the projects and beyond.

The participatory research aimed to assess STI/HIV prevalence, understand social and behavioural correlates and characterise the access to sexual health services among most vulnerable populations. In each project, all partners participated in the definition of the study objectives, outline of the methodological procedures, design of the questionnaires, as well as in the implementation of the field work, and interpretation of the findings. Methodological procedures are described elsewhere (Dias et al., 2015, 2020; Gama et al., 2017). Data were collected by interviewers, who were members of NGOs, CBOs and also migrant, SW and MSM peers. In each project the interviewers were coached in collecting quality data through training sessions. These sessions were dynamic, where everyone provided feedback and actively participated in the debate about dubious questions and terminology used in

the questionnaire, the approach to invite potential participants and the procedures to obtain the informed consent and to administer the questionnaire (Dias et al., 2018). In total, 13 migrant peers/representatives and members of NGOs and CBOs working with migrant communities, 60 SW peers/representatives of NGOs and CBOs working with SW and 31 MSM (peers and NGO/CBO members) were enrolled as interviewers.

Based on the evidence produced, interventions were developed, which are aimed to adequately address communities' specific needs identified through the participatory research (Dias et al., 2018). The developed interventions covered peer education, among other initiatives (e.g. HIV services/organisations mapping; information, education and communication activities; HIV testing initiatives in community-based settings) and were planned and implemented in close partnership with the NGOs, CBOs and civil society partners. This process enabled institutional capacity building on advocacy for sexual health promotion and rights and also enhanced the empowerment and the capacity of communities to understand their health needs and redirect their efforts in addressing them (Dias et al., 2018). Peer education initiatives specifically were implemented by members of the SW and MSM peer group who were influential in triggering changes in knowledge, skills and behaviours among their peers, as well as in contributing to promote access to healthcare. A total of 25 MSM peer educators trained other peers to disseminate risk reduction information within their social networks. Among SW, six peer educators were trained and were integrated on NGOs outreach teams.

Another experience was the European Sialon II project focused on the promotion of sexual health and prevention of HIV infection targeting MSM, including those migrant and travellers. Globally, it aimed to build capacity among non-governmental organisations (NGOs), public bodies and academic partners in implementing biobehavioural HIV research combined with targeted HIV prevention. As such, a multicentre biobehavioural cross-sectional survey was conducted in 13 European cities, including Lisbon. Details of the study methods are described elsewhere (Gios et al., 2016). The project adopted a participatory approach by involving members of local MSM communities in its conception, development and implementation (including formative research, participant recruitment, data collection and prevention activities), as well as evaluation, interpretation and dissemination of the findings (Gios et al., 2016, 2021). An initial formative research was conducted to help select data collection settings and identify prevention needs. MSM were recruited in gay-friendly commercial venues and non-commercial sites. A self-administered questionnaire was applied to collect participants' socio-demographic and behavioural data, and afterwards biological samples were collected for HIV antibody testing, with all respondents being entitled to collect their test result at a nominated centre.

Overall, 15 'community researchers' contributed to the construction of the data collection instruments, design of the participant recruitment strategies and sexual health promotion content and also collaborated in the participants' recruitment and data collection process. Most of these community researchers belonged to local gay community-based organisations or were experienced in sexual health promotion and HIV prevention among MSM communities but also included MSM peers. To

ensure standardisation of research procedures, a 2-day dedicated training was provided to the community researchers that covered the study's purpose and procedures, safety, ethical aspects such as confidentiality and capacity building. Community researchers used standardised tools (i.e. questionnaire, prevention manual). Data collectors also acted as prevention outreachers distributing a prevention 'info-pack' with a leaflet with information on local HIV prevention and testing services and also condoms and lubricants. This experience showed that involving the community partners in the elaboration of the research protocol, in training, and in the development and delivery of prevention activities, contributed to the successful implementation of the study but also to increase trust and potentially to reduce research fatigue among communities (Dias et al., 2021). This can pave the way for communities' capacity building, with key actors and peers developing skills and resources for sexual health promotion. Similar experience in participatory health research projects among migrant populations has shown the value of engaging migrants in the definition of the research agenda, the design and implementation of health interventions, the identification of health-protective factors and the operationalisation and validation of indicators to monitor progress (Roura et al., 2021).

Overall, these participatory research experiences constituted an intervention by increasing all actors' capacity to address the sexual health promotion. It contributed to enhancing individuals and civil society' awareness and commitment to sexual health issues, access to HIV prevention information and testing and increased information about where to get tested and treated. Community-based organisations also developed a more reflexive practice, increased capacity for monitoring their activities and became better informed to address communities' health needs and advocate for sexual health rights (Dias et al., 2018).

Challenges of Intercultural Health in Mexico: Reflections from the Comprehensive Hospitals with Traditional Medicine Program

Mexico is a country with a multilingual and plurilingual tradition. According to the Intercensal Survey of the National Institute of Statistics and Geography (Inegi, 2015), the indigenous population in our country totals 25 million people. Regarding the state of Puebla, it is ranked fifth among Mexican states, with an indigenous population amounting to 1,094,923 people, which represents 18% of its total inhabitants (Inegi, 2020).

In terms of healthcare directed towards this population segment in Mexico, the right to intercultural health has been one of the most relevant commitments undertaken by various governments in the last 20 years. Thus, the intercultural health paradigm has been supported by both national and international legal instruments; however, this is also a right that is not in full effect yet in our country. In fact, the Mexican State has not yet been able to provide the necessary care or medical

services in all of Mexico, much less in accordance with an intercultural approach. Nor is this section about discrediting the progress and efforts that have been made on the subject, but 'there are still several pending elements in terms of medical care, human resources for community clinics and infrastructure/equipment for clinics and hospitals' (México, 2018).

It should be recalled that the right to healthcare for indigenous peoples is established in International Labour Organisation Convention No. 169 Concerning Indigenous and Tribal Peoples in Independent Countries, which mentions in its article 7, section 2, the obligation governments have in relation to the 'improvement of the conditions of life and work and levels of health and education of the peoples concerned, with their participation and cooperation, shall be a matter of priority in plans for the overall economic development of areas they inhabit' (México, 2003).

Mexico has not been oblivious to this; one need only refer to the fact that the National Health Program (2001–2006), signed by President Vicente Fox, contains the following statement: 'In a very close position, health is also an essential element in relation to access to life opportunities […] it is urgent and necessary to recognize the different health care systems in Mexico, which should not be opposed, in a way towards a model of intercultural health where there is recognition of allopathic medicine but also traditional medicine' (México, 2001a, p. 6).

On that basis, the path towards the construction of an intercultural healthcare system was perceived not only as having many uncertainties and challenges but also as having a great deal of hope and commitment; in this sense, institutions and regulatory bodies were created in relation to the subject, such as the Directorate of Traditional Medicine and Intercultural Development, created in August 2002, within the context of the recognition of cultural diversity and the emergence of new healthcare models. Its main role has since been to 'define and promote intercultural policies in connection with the provision of institutional services, with a vision in alignment with gender perspectives as well as an innovative vision that promotes an interconnection between traditional Mexican medicine and the so-called Complementary Medicines, which are found among the preferences of society' (México, 2001b). Hence, one must ask oneself: in Mexico, why, despite the fact that the national healthcare system has been prioritised, do millions of Mexicans continue to invest in alternative health practices in their daily lives? In this regard, Campos (2020) notes that people do not seek traditional healers or doctors as a result of ignorance, obscurantism, superstition or fanaticism. 'In many rural areas in Mexico, people seek these healers because they are the only professionals who live in the area, since – despite government strategies to extend the coverage of modern medical services – it is not possible to cover the entire territory' (Campos, 2020, p 8).

Given these needs and in this regard, a proposal was made to create the State Coordination of Comprehensive Hospitals with Traditional Medicine Program. Within the universe of the healthcare services of the state of Puebla, the Comprehensive Hospitals with Traditional Medicine Program (PHIMT) was created in 2002, the main goal of which being to provide mixed healthcare services and provide spaces where traditional medicine and allopathic medicine are developed within a framework of interculturality. Thus, a technical work group was put

together, made up by federal planning officials and the General Coordination of the Puebla-Panama Plan, with the purpose of optimising healthcare quality.

The Implementation of PHIMTs

Since the constitutional reform in 2000, with priority given to indigenous peoples, the state of Puebla has submitted six projects to public tender, including the PHIMTs. Their main goals were to provide mixed healthcare services, a traditional module and an allopathic medicine hospital. 'This project arose from the acknowledgment of a distance separating allopathic medicine and indigenous populations, as well as from respect for such populations' culture and form of organization, since they have a wealth of knowledge and valuable practices to protect their health' (Gutiérrez et al., 2008, p.4).

The Comprehensive Hospitals with Traditional Medicine Program was initially implemented in five cities, in which there are an equal number of comprehensive hospitals and where most of the ethnic groups in the state are concentrated: Coxcatlán, Ayotoxco de Guerrero, Huehuetla and Cuetzalan.

There are two kinds of personnel in the modules: coordinators, who are in charge of attending to all the needs of the module and of the materials for the preparation of products, making sure everything is working well, and translators, who are people who speak indigenous languages and translate to allopathic doctors or traditional doctors everything the patient requires.

According to Tapia (2014), the central goals of this healthcare model is seeking a close relationship between allopathic medicine and traditional indigenous medicine, as well as guaranteeing appropriate spaces for the development of these two models, thus contributing to the improvement of healthcare and living conditions of indigenous populations. However, not much has been achieved due to the weight attributed to scientific knowledge. On the one hand, to date many diseases that are not recognised by science, such as fright, sadness and pain, among others, continue to be disregarded, as well as those related to spirituality. So, the important thing is to question and analyse how far we can promote and guarantee – beyond public policies, the national development plans, the national healthcare plans, discourses, etc. – the implementation of an intercultural healthcare system, when we continue, from our colonialist and Western perspective, to train healthcare professionals based on the scientific method, something that automatically tends to discredit and condemn alternative healing practices other than allopathic medicine that are for that very reason disregarded, such as traditional and herbal medicine, as well as midwifery practices.

This is based on fieldwork that clearly shows how doctors and nurses in these interaction spaces end up silencing and ignoring traditional healers and midwives, disregarding their ancestral knowledge and expertise, as it happens between teachers and students. The most unfortunate thing happens when healthcare professionals come from indigenous communities, which is why the issue of interculturality is

very complex and with serious fragmentations; in many cases, as it happens at school, this situation becomes tinged with interethnic conflicts and results in cultural tensions.

This has been possible to study thanks to the various research projects that we have been developing with undergraduate and graduate students in the healthcare area at the Benemérita Universidad Autónoma de Puebla. In conclusion, it is undeniable that conflicts involving different medical systems arise not only from the differences in the explanatory models that support them but also from the social domination of one healthcare model over another, as explained Jorge Gasché (2008) would say, and a relationship of dominance and submission, which is the end result of a colonisation process.

The teaching and learning practices based on interculturality and carried out at integral hospitals in Puebla represent a huge challenge for the promotion of health of traditional peoples. On the one hand, these practices demonstrate the government's effort to recognise the indigenous people's rationale in the face of the health-illness-cure process. On the other hand, integrating Western scientific reaction into traditional knowledge requires permanent educational processes that ought to be carried out with the participation of all agents involved in the care practices of traditional peoples.

Popular health education, the values and assumptions of which are anchored in Paulo Freire's pedagogical teachings, can be a valuable tool in educational processes that advocate interculturality. The tools that make up popular education in health are dialogue, participation, respect for traditional knowledge, loving-kindness and shared construction of knowledge (Pedrosa, 2007).

The experience carried out in Puebla can be an inspiration for other countries, especially the ones whose population is also made up of traditional, indigenous or African peoples. The elaboration of projects that propose health promotion and the provision of care within an intercultural perspective have great potential to offer comprehensive care to these populations.

Permanent Education Program for Community Health Agents (PEPACS) in Porto Alegre, Brazil

Primary healthcare (APS), its principles and guidelines, has been increasingly used in Brazil to consolidate the Unified Health System (SUS) (Almeida, 2013). Among the strategies and projects created and implemented within the scope of APS, one deserves mention for having enabled access to and quality of healthcare to users who live in areas of difficult access in the country: the Community Health Agents Program (PACS).

The PACS, created in the 1990s, advocates for an articulation between the community and healthcare professionals, promoting actions to guide healthcare services directed towards the community attended and to expand associations with services

(Brasil, 2001). Over the years and during the elaboration of the National Primary Care Policies, the PACS has changed.

Currently, the primary strategy behind APS organisation in Brazil is the Family Health Strategy (ESF), which consists of teams made up by at least one physician, a nurse, a nursing technician and a community health agent (ACS). The latter is someone who must necessarily live in the community where the ESF team works and have the suitable profile to carry out health education actions and the integration of the community with the ESF team. He/she is a full-time healthcare professional who receives compensation but without prior training to practice the profession. That is, this professional learns this professional practice in the course of his/her activities.

Within the context of the Brazilian APS, the professional qualification and training of ACSs, carried out through a strategy entitled 'Agents in Action', are provided for.

Such strategy must be guided by the National Policy for Permanent Education in Health (PNEPS), established by the Ministry of Health in 2004, which aims to 'make contributions to change and qualify health care, as well as organize actions and services, training processes, health care practices and pedagogical practices' (Brasil, 2004 p. 3). This policy intends to guide permanent education strategies aimed at healthcare professionals, seeking to expand the resolution capacity of the services provided, according to local needs and possibilities.

Additionally, the ACS permanent education strategy is in alignment with the National Health Promotion Policy (Brasil, 2014), which advocates, among other actions, within the scope of its set of foundations and skills, the execution of activities in the territories where the APS teams, called Family Health Strategy (ESF) teams in Brazil, work. More specifically, the PNPS provides for the 'support for training and continuing education in health promotion in order to expand the commitment and also critical and reflective capacity of health care managers and workers, as well as an incentive to improve individual and collective skills, aimed to strengthen sustainable human development' (Brasil, 2014 p.1). With the goal of offering in-service training in line with the PNEPS and PNPS concepts, based on the perspective of considering health education as a vital process of exchange between individuals and offering educational activities that contribute to the production of knowledge by workers with regard to their daily practices, the Permanent Education Program of Community Health Agents (PEPACS) was created as a university extension initiative, in a partnership between workers in the municipal healthcare system in Porto Alegre, Brazil, and students from the Collective Health Program at the Federal University of Rio Grande do Sul (UFRGS). In addition to the agents and public health workers in training, the program was also attended by teachers, students, workers and professionals from various areas, according to the topics covered in each meeting (not only in the healthcare field): nurses, physicians, dentists, occupational therapists, psychologists, physiotherapists, physical educators, pharmacists, nutritionists, visual artists, musicians, designers, theatre groups and communicators.

The methodological procedures used in conducting the PEPACS are founded on the dialogic perspective of building knowledge collectively and are epistemologically based on Freire's pedagogical theory and its principles (freedom, constructivism and dialogically) (Brandão, 2005). Hence, the ACSs' experiences and vocabulary were used to elaborate the axes and themes to be approached and discussed in the activities proposed, taking into account that learning for (and at) work allows for freedom of expression and provides subsidies, from people's own experiences, for reflections on the actions carried out (the praxis), resulting in new critical and denaturalised actions.

Thus, the activities were developed in four stages. In the first stage, action planning, a general meeting was held, in which all ACSs of the territory where the program was to be implemented were invited to present the proposal and its main purpose.

In the second stage, talks were held with the ACSs in the territory where they operate. The purpose of these meetings was to identify main topics (or 'generating words', according to Paulo Freire's methodology) and to look for, in the workers' routines, subsidies for their own teaching-learning process. Therefore, the ACSs would find a space to discuss and (re)signify their work and world (re)cognition processes.

In the third stage, the results of the previous one were released and the PEPACS program was developed. Thus, the dates, the topics to be discussed, the pedagogical strategies and the necessary infrastructure were defined, and institutional support was requested for the activities that were to be carried out. The main topics defined in the second stage were brought together in discussion axes, based on the established number of meetings and the relatedness of the topics.

The fourth and last stage involved the execution of pedagogical activities. This was the phase in which a critical-constructivist exercise was practiced, that is, the ACSs met with moderators (UFRGS faculty and students, and guests, according to the topic addressed each meeting) in order to discuss these main topics, sharing experiences, reflecting on activities and establishing a new, conscious and transformative practice.

At this stage, we sought to build skills for the practice of health promotion actions in the territories where the ACSs operate. These skills are within the scope of the fundamental elements of health promotion in Brazil: health education, operation in the territories, community participation, empowerment of individuals and communities, comprehensiveness of care, cross-sector action, sustainability and equity in healthcare services and territories (Brasil, 2014).

Three meetings were held, each lasting one shift. In the first two meetings, the ACSs were divided into two groups, one in the morning shift and the other in the afternoon shift. The third meeting was held with all the agents attending it in the same 'extended' shift (lasting approximately 6 hours). The discussion axes for each shift were as follows:

1. Occupational risks, violence and discrimination
2. Tuberculosis, HIV/AIDS, drugs and prejudice

3. Professional cooperation, work environment and work management

The first meeting featured a presentation by a theatre group in which the actors enacted two possible approaches of the ACSs during a home visit.

On this day, the topics proposed in Axis 1 were addressed, and the ACSs were divided into smaller discussion groups that analysed and discussed issues related to the proposed themes:

(a) Violence within the community and the power of groups associated with drug trafficking
(b) Recruitment of minors for drug trafficking activities
(c) Young women's involvement in drug-related activities and teenage pregnancies, a situation in which the ACSs identified the importance of establishing a dialogue with drug lords operating in that area in order to avoid conflicts that may jeopardise their professional activities
(d) Mental health and its difficulties in the community
(e) The difficulties found in the relationship between the ACSs and users of psychoactive substances, with ACSs identifying the importance of their work and seeking to build a relationship based on trust and respect, as well as referring users to the healthcare services provided by the SUS network, such as the Psychosocial Assistance Centres (CAPS), in addition to other situations related to mental health
(f) Behavior of residents/users towards ACSs, ACS health and ways to deal with sick users
(g) Animals being abandoned on the streets and 'attacks by dogs/cats' suffered by ACSs
(h) Care provided to the elderly and dealing with old people being abandoned by their families and the professionals being responsible for contacting their families and making daily visits with the purpose of creating a bond and, therefore, making the necessary referrals
(i) Users' resistance to treatments and conducts, among other issues, in particular when it comes to those who need controlled medication (users with tuberculosis and/or HIV) and require several visits a day so that ACSs make sure users do not quit their treatment

Then, the ACSs also raised the need for an active and strong professional union, which would assist them in discussions related to their profession (work regulation and management), in addition to claims regarding healthcare benefits. Due to the importance of the accounts that emerged, we suggested the creation of a work group aiming at creating an association of ACSs, in order to make sure they have a space for claiming their rights.

In the second meeting, focused on 'tuberculosis, AIDS, drugs and prejudice', we first watched a video about prejudice in the various scenarios that permeate the provision of healthcare services. At this meeting, we worked on Axis 2, and the main pedagogical strategy used was to discuss cases created based on life stories similar to those they experience in their daily lives. The groups were instructed to discuss the stories in order to find possible solutions to the problems presented, in such a way that they, as ACSs, could indicate possible solutions for the cases under discussion.

Many ACSs identified similarities between the stories told and their work reality and, from their comments, many collective strategies aimed at facing such situations emerged. At the same time, some ACSs showed some resistance to admit the possible limitations they find, in their daily lives, to deal with the stories being discussed. This was a key moment for the moderators to intervene and break apart some prejudices, including other perspectives of analysis.

At the end of the second meeting, the keywords having been identified by the moderators, a collective display, designed collectively, were built featuring the topics of the meeting as well the possibilities of referrals mentioned by the people participating in the discussion.

In the third meeting, focused on the topics of Axis 3 (professional cooperation, work environment and work management), all participants presented their reflections on issues raised by their colleagues. They expressed the troubles and fears they find in their daily activities and analysed issues related to work management. They also said that they often do not receive any support from the team, which ends up constraining their activities.

In this meeting, which was the biggest one in terms of duration, we organised a collective snack break featuring musicians who instigated the participants to make up verses on the topics of the meeting, based on popular songs. It was very fun and interesting to bring a softer side to a difficult topic, such as work relations, with the collective composition of verses and songs that allowed us to experience this topic with other emotions as a starting point.

It is important to observe that we had in this meeting, as well as in previous ones, moderators (guests) who helped the ACSs with regard to any questions they had. Some moderators were healthcare workers, while others were workers from other areas or professionals linked to the university.

The implementation of PEPACS points to some important issues that must be highlighted:

1. The need to establish and/or strengthen communication channels between healthcare services and the university, since one of the latter's goals is training and qualifying workers
2. The need to strengthen the recognition and the importance of ACSs within the community so that they can be truly appreciated
3. The strengthening of entities representing these healthcare professionals
4. The importance of the involvement of managers in the conduct of similar programs, since many discussions and decisions made in the development of this program will have a direct influence on the organisation of healthcare services
5. The importance of ACSs being able to have their 'new' routine, based on the reflections made and on the support of their superiors in the organisation of work activities, as these superiors are the ones who regulate the daily practices of the ACSs

Finally, it should be stressed that the National Policy for Permanent Education in Health formalised (or rather institutionalised) the various experiences carried out within the scope of teaching-learning practices, as well as encouraging the creation

and maintenance of these strategies in various health services, as was the case with the implementation of PEPACS.

In turn, the National Health Promotion Policy reinforces the need to carry out actions supported by permanent education, in order to enable the construction of skills to carry out health promotion practices in the territories where APS operates. The teaching-learning process for such skills proved to be effective when carried out through the use of active methodologies while respecting the culture and knowledge of the agents involved in the training process. The way through which it was conducted – considering the ACSs' own experiences – contributed to their re-signifying their work practices.

For all these reasons, we hope that such a program may encourage the multiplication of similar initiatives in the various locations where ACSs operate in Brazil and where APS professionals operate in other parts of the globe, safeguarding local culture and experiences so that their appreciation and incorporation by healthcare teams can be ever greater.

This experience of teaching-learning skills for the practice of health promotion activities proved to be effective through an evaluation carried out with the ACSs. Therefore, initiatives within the scope of permanent education in health programs, anchored in the shared construction of knowledge, the use of active learning methodologies and the respect for the local culture and knowledge of the people involved, are revealed as health promotion teaching-learning experiences that can be replicated in other scenarios, taking into account the realities of each one involved.

Final Considerations

By reporting and discussing these three teaching-learning experiences in the field of health promotion, we highlight their common elements and their respective specificities. The reported practices are in alignment with one another as they make use of participatory and dialogic tools, a shared construction of knowledge and the respect for the culture of various population groups.

The experience in Portugal presented an account of a participatory research, aimed at the population group of men who have sex with men (MSM). The strategy used was to train members of the community that was the object of the research to collect data. According to the account of this experience, the involvement of members of this specific population group was powerful in the sense that it enabled the construction of new knowledge from the confluence between researchers and members of the community being researched.

In Mexico, the construction of hospitals for comprehensive care, based on interculturality, provides for the confluence of the knowledge of traditional indigenous peoples and the scientific knowledge of healthcare professionals. This experience represents a very important advance in the perspective of the health promotion of traditional peoples, insofar as it proposes that healthcare services be carried out while respecting their culture, at the same time providing the necessary

technological resources for assistance. The main challenge, however, lies in the construction of truly intercultural care, without one kind of knowledge imposing itself upon the other, so that respect for the healing wisdom of traditional peoples may be effectively present.

Finally, the experience in Brazil, which refers to the permanent education of community health agents, focused on teaching and learning health promotion, revealed that the use of active methodologies, capable of taking into account the life and work realities of ACSs, as well as their knowledge and culture, was a powerful experience for developing skills in the field of health promotion. The ways of questioning elements of these professionals' daily lives, based on how they interpret the world, favoured the teaching and learning of topics that are part of the health promotion field, in a way that was capable of providing them with tools so they can act as health promoters in their day-to-day activities in primary healthcare.

We believe that the reported teaching-learning experiences have the potential to be reproduced in other contexts, since they have, as a guiding principle, educational processes based on participatory and dialogic tools, on the shared construction of knowledge and on the respect for the culture of various population groups. The three experiences were deemed successful in building and developing skills in the health promotion field. Therefore, they can be adjusted to different realities, as long as the pedagogical principles used are observed.

Table 40.1 brings our reflection on the six triggering questions suggested by the editors.

Table 40.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	We consider health promotion to be a heterogeneous field in terms of practices and knowledge
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	We report three experiences. Portugal: training experiences of community researchers to work with their peers in participatory research on sexual health promotion among most vulnerable populations, including migrants, sex workers (SW) and men who have sex with men (MSM) and meetings for knowledge sharing between projects partners. Three training initiatives and several regular meetings were promoted and included staff from local NGOs, community-based organisations, individuals experienced in sexual health promotion and HIV prevention among those communities and migrant, SW and MSM peers. Mexico: promoting comprehensive care for traditional indigenous peoples. Two international meetings, two national meetings and one regional meeting were held. Professionals in the fields of linguistics, sociolinguistics, sociocultural anthropology and educational anthropology participated in these meetings. Brazil: training of community health agents in order to develop skills in the area of health promotion. Three meetings were held, with the participation of the following professionals: community health agents, nurses, physicians, public health officers, speech therapists, physiotherapists, social communicators, psychologists, social workers and pharmacists

(continued)

Table 40.1 (continued)

Questions	Take-home messages
Which theories and methodologies are used in the teaching-learning process?	The experiences carried out in the three countries have in common the use of participatory and dialogic tools, a shared construction of knowledge and the respect for the culture of various population groups. The experience in Portugal featured the report of a participatory research, this type of research being its main theoretical and methodological support. The experience in Mexico showed how integral hospitals were created for the care of traditional peoples. The supporting theory was interculturality. In Brazil, the report referred to the training of community health agents. The methodology that provided support to the activity was the Permanent Education in Health policy
What forms of assessment are applied, results achieved and challenges faced?	Portugal: regular meetings, workshops and focus groups conducted with CABs and projects partners allowed to assess the processes and outcomes of the projects' implementation. A main challenge was to assure that the outcomes of the participatory research in terms of creation of new connections between partners, exchange of knowledge, resources and support and adoption of innovative practices were sustainable overtime México: qualitative assessment, prioritising an ethnographic approach. Challenges: it is vital to promote the training of professionals, in all areas, within an interdisciplinary perspective and with an intercultural approach. Brazil: qualitative assessment; the beginning of a process aimed at recognising the importance of ACSs for the whole group of healthcare professionals working in that territory was certainly its greatest benefit. On the other hand, the biggest challenge is related to the countless setbacks we had (and still have) to maintain the Family Health Strategy and the Community Health Agents Program in the city of Porto Alegre
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	The three experiences allude to the pillars of autonomy, empowerment, participation and shared construction of knowledge by the organisers of the activities and the individuals and communities involved. The main strategy of these three experiences is to maximise the potential of local knowledge to build skills for health promotion among peers
What others could learn with your experience? What is localised and what is 'generalisable'?	We believe that the reported teaching-learning experiences have the potential to be reproduced in other contexts, since they have, as a guiding principle, educational processes based on participatory and dialogic tools, on the shared construction of knowledge and on the respect for the culture of various population groups. Peer education can be reproduced in different contexts, as long as the pedagogical principles and cultural characteristics of each location are observed

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Chapter 41
Community-Engaged Education in Health Promotion: Exploring Equity and Ethical Dimensions to Problem-Solving in Community

Paola Ardiles Gamboa and Tara Fernando

Contents

Introduction

The COVID-19 pandemic has inevitably changed the landscape in health promotion due to the exacerbation of social and health inequities that have resulted from the wide range of public policy responses to the pandemic around the world. Addressing the expanding social determinants of health requires intersectoral approaches with a wide range of actors, including policymakers, public health professionals and academics. Notably, it is important now, more than ever, to equip students with strategies to meaningfully engage, empathise and identify community health needs in order to solve complex problems impacting health and wellbeing. However,

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traditional classroom and lecture-based methods of teaching and learning are no longer sufficient in providing students with the necessary knowledge and/or skills to become active social change-makers, calling for innovative approaches to education (Ardiles et al., 2021; Cronin & Connolly, 2007).

With advancing technology and shifting societal demands, higher education institutions are increasingly looking to offer more fulfilling, engaging and interactive courses to their expanding student populations (Berghaeuser & Hoelscher, 2019). The growing demand for unconventional academic opportunities, and the pressure from external stakeholders to better prepare students for 'real-world' decision-making, compelled universities to become more conscious and strategic in their educational offerings (Zomer & Benneworth, 2011). In addition to teaching and research, the 'third mission' of universities emerged: institutions redirected their focus onto approaches that exist outside of the traditional modes of teaching and learning, with an aim to facilitate a meaningful, tangible, relevant and applicable form of knowledge transfer (Compagnucci & Spigarelli, 2020). As a result of this phenomenon, community engagement and experiential education have become a significant component of adult teaching and learning (Fenwick, 2000).

According to the influential Brazilian philosopher and critical pedagogy thought leader Paulo Freire, most conventional modes of education are static routines of teachers depositing information onto students and students passively collecting it (Freire, 1968/2005). Therefore, in order to stimulate a critical and tangible understanding of the 'real world', a 'problem-posing' method of teaching, one that is not bound by a strict teacher-student dynamic, but is instead a model that encourages mutual learning and growth, is proposed (Freire, 1968/2005). While experiential learning was first *officially* introduced by Western scholar, David Kolb (1984), as a holistic and transformative style of education, it is widely accepted that Paulo Freire formulated its foundations (Cunningham, 1992; Giroux, 2010; Morrow & Torres, 2002). When broadly defined, experiential learning refers to the acquisition of formal academic understandings, and informal experiences and encounters, which are evoked through an educational program (Fenwick, 2000). Experiential education often entails the involvement of multiple sectors, including academic, community and governmental, in order to provide a holistic and contextually accurate understanding of an occurrence or experience – in essence, experiential learning is rooted in the emphasis of the *every day* (Marriott et al., 2015). As institutions move away from classroom-based teaching, and towards immersive community-based settings, it is important to reject deficit-based or top-down health approaches, in exchange for new methods that incorporate human-centred, collaborative and participatory approaches (Durie & Wyatt, 2013; Green, 2005).

As indicated by Alheit (1998) and Fenwick (2000), when pursuing experiential approaches, educators must take care to not exploit the lived and living experiences of community members in order to better qualify students – instead, the benefits to the community must be predominantly identified and maximised. Consequently, when students are placed within a community context, it is critical that they are not just making passive observations of community members but, rather, that community members are actively involved within the learning and research process. Similar

to community-based research that focuses on the integration and involvement of community partners, as a way to enable co-learning, redistribute power and build community trust (Wallerstein et al., 2020); community-based education endeavours to amplify community engagement. Accordingly, community-engaged strategies first identify the integral community partners and stakeholders and then thoroughly evaluate the ethical dimensions that must be navigated – in this way, safe spaces are constructed to facilitate collaborative partnerships, the barriers to community engagement are bridged, and the roles of community members are intently incorporated within the program at hand (Mahoney et al., 2021; Marriott et al., 2015). The creation of relevant community solutions can be largely compromised if those with institutional power are far removed from the 'real-world' and operate upon the imposition that communities are helpless, incompetent and incapable (Warr et al., 2012).

The goal of this chapter is to examine the 'Health Change Lab', an experiential education program aimed at undergraduate students to explore some of the new techniques, approaches and ethical dimensions to consider in community-engaged health promotion pedagogy.

Frameworks and Approaches

While there are considerable challenges associated with successfully leading students to navigate the dynamic, complex and uncertain nature of a real-world environment, distinct frameworks and approaches can be applied to minimise the hurdles. First, teaching *systems thinking*, an interdisciplinary fusion of theories and tools, is useful to drive the importance of history and context within health promotion (Peters, 2014). Systems thinking, in essence, stimulates a deeper understanding of reality because it identifies and addresses the varying systems that influence an event (Goodman, 2018; Zurcher et al., 2018). As Durie and Wyatt (2013) have noted, equipping students with systems thinking and transdisciplinary knowledge allows for a more informed and empathetic understanding of the community and its people.

Second, interdisciplinary and transdisciplinary approaches ensure that students are not just passively absorbing lecture material but that they are instead constructing and deconstructing fragments from varying sources in order to wholly understand a concept (Budwig & Alexander, 2020). The interdisciplinary approach allows multiple disciplines, along with their distinct themes and frameworks, to weave and intersect, generating the ability to perceive contexts in ways that realistically reflect and acknowledge the intertwining, multifaceted nature of the 'real world' (IBoC, n.d.). Particularly, the interdisciplinary approach emphasises novel techniques, such as team-teaching', where instructors from distinct backgrounds co-design and co-conduct educational programs, to diversify and enrich the availability of knowledge for students (Jones, 2009). Similarly, the transdisciplinary approach dissolves traditional social, political and health boundaries, constructing a mind frame that is

dynamic and multifaceted (Knerr & Fullerton, 2012; Soskolne, 2000). However, the transdisciplinary approach encourages the in-depth understanding of each individual discipline, surpassing static learning strategies (Kaufman et al., 2013). As a result, the application of transdisciplinary thinking drives a deeper understanding of history and context, ultimately strengthening the understanding of community challenges and, thereby, the development of practical solutions (Stokols et al., 2013). All in all, both interdisciplinary and transdisciplinary perspectives prove exceedingly beneficial within health promotion because they equip students with the skills to actively engage, deconstruct, question and expand varying contexts and situations before reaching conclusion and/or making assumptions.

Third, the use and practice of social innovation theory is beneficial in a real-life setting to enable participation and collective action through the co-design of novel solutions; social innovation theory works to cultivate meaningful partnerships, and it acts as a catalyst for social and policy change (Ardiles et al., 2021; Farmer et al., 2018). A social innovation approach stimulates the construction of new, inventive and creative solutions to social problems, solutions that are acutely relevant and widely applicable (Phills et al., 2008, p. 36). While a relatively novel concept, social innovation theory exhibits promising attributes for targeting the social determinants of health: it is easier to address community challenges with the insights and experiences of community members than it is as a complete outsider (Ardiles et al., 2021; Dako-Gyeke et al., 2020).

Finally, human-centred design is useful in identifying and addressing community challenges as it employs a participatory approach to problem-solving (Ardiles et al., 2021). Design thinking entails working with diverse stakeholders and community members, as a way of developing health promotion strategies that are relevant, applicable and sustainable (Luckin et al., 2006). The human-centred design process is a non-linear, iterative strategy that comprises five key phases: empathise, define, ideate, prototype and test (Pinedo, 2020). In essence, this approach is designed to stimulate a deeper understanding of a problem by guiding community members (referred to as 'users' in the context of design work) to identify and define a problem, analyse the origins of the problem and understand how implicit biases shape one's perception of the problem. Further, the user-centred relevance highlighted by design thinking prompts the ongoing tangible prototyping and user testing of the proposed by undergoing multiple feedback loops to ensure the community perspective is at the center. With an emphasis on empathy, this approach builds off of the age-old idiom 'learn to walk a mile in someone else's shoes' but takes it one step further by asking '*how* can you walk a mile in someone else's shoes when your lived and living experiences are so different'? Much like social innovation theory, at the core of human-centred design is the introduction of innovative, feasible and applicable community solutions (Ardiles et al., 2021; Pinedo, 2020).

New techniques and approaches to health promotion education are essential to develop future professionals who have the capacity to dismantle the current flawed mechanisms that highlight community deficits and assume community helplessness (Ardiles et al., 2021; Durie & Wyatt, 2013). In alignment with the fulfilment of the community engagement strategies in post-secondary settings, it is essential that

innovative, holistic and engaging programs and opportunities are introduced amongst the traditional teaching and learning courses. The above-mentioned five frameworks and approaches, when used in conjunction, establish an understanding of community, context and health, which transcends conventional teaching methods, enabling students to accurately advance health promotion strategies.

Background

In 2015, Simon Fraser University (SFU) located in British Columbia, Canada, created an innovation strategy, in line with their strategic mission to be '*the engaged university* committed to engaging students, research, and communities' ('Strategic Vision – SFU Engage – Simon Fraser University', 2021), generating a new opportunity for program development. The SFU Faculty of Health Science and the RADIUS Social Innovation Hub, Beedie School, collaborated to design the Health Change Lab (HCL) as an iteration of an earlier experiential and interdisciplinary undergraduate program 'Change Lab' (RADIUS SFU, n.d.). Since its conception in 2015, the HCL has undergone multiple enhancements and improvements; however, at the core is the goal to engage students and local community partners to solve complex problems related to community health.

The HCL is an intersectoral collaborative initiative situated in the City of Surrey, Canada. It involves interdisciplinary teams of undergraduate students and instructors from SFU, as well as key partners from the local health authority (Fraser Health Authority), the municipality (City of Surrey) and various non-for-profits in Surrey. Currently, the HCL is offered every fall semester, is open to students in all faculties and is directed at third- and fourth-year undergraduate students.

Setting and Context

The City of Surrey is situated on the traditional territories of the Semiahmoo, Kwikwetlem, Qayqayt, Kwantlen, Katzie and Tsawwassen First Nations; it is the second-largest municipality in British Columbia (BC), Canada (City of Surrey, 2016a, 2020a). Surrey is the fastest-growing city in BC, the fastest-growing home of BC's Urban Indigenous population and often the destination of choice for refugee claimants and immigrants due to the high cost of living in the neighbouring city of Vancouver (City of Surrey, 2020a; FHA, 2015). With nearly half of Surrey's residents being immigrants, and a third speaking English as a second language, Surrey is one of the most culturally diverse cities in Canada, rich in religion, language and tradition (City of Surrey, 2016b, 2020b).

Given Surrey's vast and varying demographic factors, including its rural-urban composition, socioeconomic status arrangement and age range distribution, multiple exclusive areas of concern are both pre-existing and steadily emerging (Ardiles

et al., 2021; City of Surrey, 2016a, 2016b). For example, when considering areas with greater youth densities, prevailing transportation and accessibility limitations can impede youths' utilisation of recreational centres, calling for solutions that prioritise the location of facilities and programs (City of Surrey, 2018). Alternatively, when evaluating areas with higher immigrant proportions, arising challenges associated with cultural unfamiliarity and language barriers may indicate a need for the development of accessible programs that aid community navigation (City of Surrey, 2018).

Ultimately, the unique health and community needs of Surrey's diverse population demand the careful re-evaluation of the available support systems, public infrastructure, healthcare distribution and income assistance, in order to thoroughly satisfy everyone (City of Surrey, 2018). Accordingly, in 2015, stakeholders and policymakers agreed that substantial work had to be done to meet the needs of Surrey's steadily growing and diversifying population (City of Surrey, 2016a, 2016b; Surrey Poverty Reduction Coalition, 2015). Notably, the city of Surrey recognised the importance of meaningful partnerships, making space for a collaboration between academic institutions and the City of Surrey.

Overview

The HCL is an innovative educational program that aims to educate future health promotion practitioners to apply an equity lens in order to solve complex problems that impact community health, such as food insecurity and social isolation. Within the 13-week semester, a team of interdisciplinary teachers facilitates the student cohort to work in small teams that are expected to collaborate throughout the semester with community partners and co-create sustainable, feasible and viable solutions to a community health challenge.

The HCL is made up of both health science and business courses and features a curriculum on systems thinking, community engagement and human-centred design. First, given the interdisciplinary nature of the student cohort, systems thinking is used to introduce students to the social determinants of health and the multifaceted structural inequities that propel community challenges (Ardiles et al., 2021). Second, with a requisite for interviews and outreach, community engagement is applied to ensure that community voices are emphasised throughout the design process (Ardiles et al., 2021). Third, using both systems thinking and community engagement, the human-centred design approach is used as a means of promoting community health through the participation of community partners in the creation of relevant solutions to community health problems (Ardiles et al., 2021).

In accordance with the core frameworks and methodologies used throughout the program, there are eight learning objectives that are integral to the HCL. Given the limited duration of the program, in comparison to its extensive goals, the seven objectives provide both the instructors and students with a general pace and outline to follow.

1. Teams access and analyse data from multiple sources, perspectives and disciplines, using both primary and secondary research approaches.
2. Teams recognise patterns and generate insights from data collected using various health promotion and social innovation frameworks.
3. Teams creatively prototype possible solutions and iterate based on feedback.
4. Teams create a business model and test the assumptions within it.
5. Teams effectively communicate and engage different audiences, using a variety of media and representations.
6. Students practice dialogue, in various forms and formats, while engaging in project work in the community.
7. Students develop self-directed learning goals and reflect on learning throughout the program.
8. Students utilise critical reflexiveness in health promotion and community engaged work.

Originally, the HCL was designed to be conducted by two instructors as a 7-credit, two-course curriculum program, including one health science course (HSCI 495 – Applied Health Sciences Project) and one business course (BUS 453 – Sustainable Innovation). However, after results from a study of the first iteration of the HCL emphasised the benefits of the design process, and because community partners highlighted the advantages of having two interdisciplinary instructors, the program was expanded (Ardiles et al., 2021). A second business course (BUS 494 – Design for Innovation) and a third instructor were introduced to thoroughly cultivate a learning environment rich in resources and interdisciplinary perspectives. With these iterations, the HCL expanded into a 10-credit, three-course curriculum program, led by three instructors, each one bringing not only their own area of expertise but also their own lived experiences.

Despite the adjustments, the interdisciplinary recruitment of students has remained unchanged across the iterations. HCL applications are open to all SFU undergraduate students across all disciplines, who meet the entrance criteria: 60 credits, 2.67 Grade Point Average, relevant work or volunteer experience and a letter of intent that outlines their reason for taking the program. Past HCL cohorts have involved students from a multitude of disciplines, including health science, business, applied science, interactive arts and technology, international relations, molecular biology and biochemistry and psychology. Both the initial HCL cohort, and the cohorts thereafter, consisted of racial and ethnically diverse students, predominantly falling between the ages of 18 and 28. Across each cohort, students identifying as female comparatively outnumbered those identifying as male or gender non-binary. In order to facilitate active participation, mentorship and relationship building, the HCL is limited to a small cohort of 20 students.

There are multiple assessment tools set in place to accurately measure the knowledge and growth of each individual student, as well as to trace the cooperation and cohesion of each team. Accordingly, the program assessments are divided into two components: individual and team-based. Since traditional assessment techniques (exams, homework, papers, etc.) take away from the core focus of the HCL, which

is centred on community partnerships and problem-solving, strategies were developed to fluidly address diverse learning styles and identify student's unique levels of personal development.

Unlike traditional class settings, students are assessed not only through their quantifiable abilities (essays, assignments), but HCL also focuses on personal growth (communication, leadership and relationship building). Throughout the semester, a significant emphasis is placed on personal development in the sense of recognising biases and assumptions, setting personal development goals and understanding one's social location in relation to the community they are working with. With the core goal of developing informed, capable and compassionate social change agents, HCL instructors transcend the passive, conventional means of evaluation.

In accordance with HCL's curricular nature, multiple learning checkpoints are distributed across the 13-week semester. The modes of assessment include writing ability (proposal paper), leadership skills (peer evaluations), personal development (weekly reflections, personal development goals), public speaking skills (mini-presentations, proposal presentation, final presentation) and development of a process book. In order to establish a concrete connection and minimise the instructor-student power dynamic, each student is assigned to a specific instructor at the beginning of the semester. Each students' paired instructor acts as a personal mentor, is tasked with conducting one-on-one check-ins, engages with the weekly reflections, facilitates the attainment of personal development goals and comprehensively evaluates student growth and development throughout the program.

Amongst the varying forms, there are four assessments that were fundamental to the HCL as a whole: weekly reflections, personal development goals, 360 peer reviews and final presentation and process book. The individual components, weekly reflections and personal development goals allow both instructors and students to track personal development and growth and also enable students to pinpoint areas for improvement. Notably, the weekly journals create a safe space for students to consistently and openly share their thoughts, including their frustrations, challenges and concerns, cultivating a safe and secure learning environment. With the ultimate goal of fostering familiarity and facilitating open communication, in 2020 the HCL cohort transitioned the submission of weekly reflections from a text to video format; despite being a minor adjustment, the change in format allows students to free-flow their raw thoughts and feelings without the constraints of word counts or grammar, maximising authenticity. The team components, 360 reviews and the final process book and presentation showcase the advancement of critical skills, including the application of systems thinking, the utilisation of the design process, the strengthening of interpersonal relationships and the improvement of public speaking and leadership. Given the importance of collaboration, the 360 peer reviews aim to advance both team building and introspection by providing an opportunity for students to evaluate themselves and their team members. Moreover, the final presentation and process book allow both community members and instructors to discern the relevancy and applicability of the proposed community solutions. First, the final process book, which details the utilisation of the human-centred

design process, allows instructors to properly grasp the steps involved in the refinement of the problem area, the selection of a solution and the undertaking of the prototyping and testing. Second, the final presentation enables instructors and community mentors to trace how their ongoing feedback and insights were incorporated when refining the final solution.

This course was designed to produce active, forward-thinking, comprehensively adept students and was *not* intended to passively examine academic material. As such, students were given concrete and consistent feedback from both instructors and community stakeholders to ensure that all the resources to refine and perfect their final assignments were readily available. Every student learns and engages in different ways, and so, the diverse assessment breakdown and criteria allowed for a unique and extensive understanding of student success. Apart from just individual development, across past programs, instructors observed collective growth across the cohort, especially in terms of understanding equity dimensions, relationship and connection building and utilising systems thinking.

Questions Arising

When developing, evaluating and reiterating the HCL, there were three main questions that were at the forefront of concern:

1. How do we work with community partners in a way that supports their priorities and meets their needs?
2. How do we build relationships and think through the ethical dimensions of our partnerships that need consideration, particularly when ‘doing no harm’ in community work?
3. How do we teach all of this within the confines of a 13-week semester-long academic program?

These three questions highlight the importance of balancing student needs while taking care to not exploit or dismiss the lived and living experiences of community members. As mentioned prior, the extraction and analysis of real human experiences as a means to fulfil an academic developmental goal is a questionable, artificial and repressive form of learning (Fenwick, 2000). Thus, community-engaged, participatory research is essential in providing both students and community members with a central role in understanding, connecting with and collaborating towards health promotion (Fenwick, 2000). The dynamic, ever-changing nature of the ‘real world’ and, thereby, the experiential learning environment pose unique challenges when it comes to a student’s interaction, reaction and interpretation of a situation. It is imperative that specific ethical considerations are thoroughly explained and established, in order to provide a safe and supportive participatory environment and to preserve and cultivate secure relationships amongst community partners.

Ethical Considerations

In 2021, SFU developed a 'Community Resource Handbook' that outlined some key challenges associated with community-engaged research and ways in which to carefully navigate and deflect them. The handbook highlights some ethical principles that are also relevant to experiential and community-engaged learning initiatives (see Fig. 41.1). These principles are adapted below to act as a guide to enable the maintenance of meaningful and equitable relationships between students and community members in the context of health promotion education.

1. Harm and Risk Reduction: This principle calls for the careful assessment of the harms and risks community members may be vulnerable to. Harms, within this sense, can refer to systemic factors relating to racism, misogyny, homophobia, etc., as well as to varying social, political and economic contexts. When conducting community-engaged education, it is imperative that potential risks are actively identified and mitigated (Mahoney et al., 2021).
2. Community Benefit: This principle elucidates that the core intention of the experiential venture must be to benefit the target community at hand. It is important that the time and trust of the participating community members are honoured through mutual community benefit – this benefit may be in the form of uniquely curated, relevant research and interventions (Mahoney et al., 2021).

Fig. 41.1 Ethical principles in community-engaged health promotion education. (Adapted from Mahoney et al., 2021)

3. Community Participation: This principle highlights the importance of designing programs that are not just *based* in a community but ones that intently stimulate community participation. At all stages of the research process (developing a research question, determining a study design, collecting data, analysing results, proposing solutions), community partners should be entirely involved. The program should make an effort to reciprocate the time, contributions and labour of the community participants (Mahoney et al., 2021).
4. Action Orientation: This principle recognises the ability of community-engaged programs to advance and transform varying systems and policies – ones that can impact the community at hand *and* broader societal structures. As such, the program should focus on responding to distinct and applicable community needs, with the aim to motivate multidimensional systemic change (Mahoney et al., 2021).
5. Power Examination and Active Redistribution: This principle instils that the student and instructors participating in the experiential learning program should be aware of their social location, power and privilege. On top of individual power examination, the program should aim to recognise the external, systemic power imbalances and generate solutions that redistribute power to the communities of interest (Mahoney et al., 2021).
6. Communication, Transparency and Trust: This principle emphasises the role that strong relationships play within community-engaged programming. In order to maintain secure and honourable community relationships and to encourage continuing community involvement, it is imperative that effective communication, sustained transparency and unfaltering trust are established (Mahoney et al., 2021).
7. Attention to Context: This principle demonstrates the vitality of consciously recognising context throughout all stages of a community-engaged program. It is important that students and instructors are aware of the intersecting social, historical, cultural, geographical and political factors which influence the community, impact the program design and ultimately determine the relevancy of the proposed interventions (Mahoney et al., 2021).
8. Focus on Relationships: This principle depicts a core necessity within all community-engaged initiatives. Community-engaged practices aim to generate collaborative partnerships, and so, it is fundamental that the relationships between people, institutions, knowledge, context and experiences are sincerely established, sustained and preserved. Above all else, it is essential that relationships are carefully built upon trust, equity and support (Mahoney et al., 2021).

Throughout the HCL program, and across all the iterations, these eight ethical principles were recognised as important considerations in the implementation of the program. Prior to the conception of the HCL, the researcher was heavily involved in the community by representing SFU on the cross-sectoral *Surrey Healthy Communities Partnership Table w*hich was chaired by the City of Surrey and Fraser Health Authority, with representation from local and provincial government agencies, as well as the non-for-profit sector. The goal of this partnership is to coordinate

efforts across sectors in identifying and tackling complex community health challenges, such as substance use overdose epidemic, homelessness and food insecurity. The researcher's active participation within the committee enabled community participation, earned community trust, cultivated community relationships and allowed for the development of a program that maximised community benefit. Specifically, in order to launch a community-engaged initiative, community members were consulted with and asked questions like 'are you interested in working with students who are involved in problem-solving?' and 'what are some community needs that are yet to be addressed'? The insights of the community members resulted in mutual benefits: the creation of a program that stimulates growth and development in students and the introduction of an interdisciplinary cohort who have the goal of addressing community concerns and developing novel solutions.

Being a sustainable venture-based initiative, the student's objectives are action-oriented and seek to propose and prototype solutions that have the potential to advance and transform systems and policies. Within the design process, community participation is driven through the inclusion of in-class lectures by stakeholders, as well as one-on-one interviews with students; the close involvement of community partners within the design process allows students to feel like they are a part of the community, and of the process, ultimately shifting and redistributing power imbalances. Particularly, students are encouraged to pay attention to context and to examine their own power and privilege as a means of establishing trust and transparency and minimising harm and risk.

One example, which exemplifies the application of the ethical principles, occurred in the Fall, 2020, HCL cohort. A student group was interested in addressing the challenges associated with homelessness; however, upon an examination of the student's social location, multiple harms related to the interviewing of people living on the street were identified. Accordingly, students instead sought out the involvement of a community organisation, Phoenix Society, a non-for-profit multi-service agency that provides temporary shelter, in order to mitigate the trauma and risks that would otherwise be imposed on the homeless community. Ultimately, the students worked with the clients of the Phoenix Society, conducting interviews and gathering insight and providing an honorarium for participating, as a means to maximise benefit and minimise harm.

While an absolute definition of 'community-engaged education' is presently undecided, essentially, the key focus of community-engaged education is the placement of community partners at the forefront of research and program designs (Mahoney et al., 2021). The effective application and utilisation of the eight above-mentioned ethical principles allow for the formation of an environment that stimulates active community partnerships and establishes a space that holistically recognises community needs (Ferguson et al., 2021).

The Evolution Towards Equity-Centred Design

In 1986 the WHO defined health promotion as a process to enable people to increase control and improve their health, and so, it is vital that the voices, opinions and experiences of those individuals and communities in question are emphasised and recognised when advancing community health programs and policies. Health is multidimensional and determined by a vast array of factors that lie outside of just the absence of disease, and as such, the strengthening of public health involves the cohesive collaboration of numerous sectors (WHO, 1986). Within health promotion, it is important that youth and future professionals are equipped with the knowledge to create healthy conditions for everyday life (through policy, advocacy, outreach, etc.); however, just knowledge is not enough – it is essential that students are able to curate the skills needed to act with communities and that community members are enabled to participate with future change agents in health promotion initiatives.

Despite the explicit demand for community-engaged health promotion strategies, the availability of academic courses and opportunities centring around applied health promotion is noticeably bleak (Marriott et al., 2015). Additionally, the existing forms of health promotion education are insufficient in providing students with the skills to tackle health challenges (Cronin & Connolly, 2007). As such, after pinpointing the clear gaps within health promotion education, the HCL was founded upon the objective of training students through multiple methodologies and frameworks, in order to generate a comprehensive and holistic understanding of health promotion. The question 'how can principles of community empowerment and participation be best embedded as we design social innovation initiatives?' was asked in the developmental stages of the HCL. Significantly, the understanding of 'health' as being the outcome of multiple interweaving, interdependent systems was identified as a central concept to translate to students. Ultimately, an intersectoral program involving systems thinking, transdisciplinary and interdisciplinary perspectives, social innovation, community engagement and human-centred design was created to optimise a diverse understanding of health.

Within the early phases of the HCL development, the need for one component became strikingly clear: a method of self-reflection. Self-reflection, although a basic concept, is a complex process that involves the unearthing, dismantling and expanding of each little fragment that makes up a person's identity and predominant perspective. Despite being a colossal feat, especially within a 13-week program, the ability to effectively self-reflect was identified as an essential skill within health promotion, as it influences the way a person knows, understands, interacts with and empathises with others. Particularly, the venture-based nature of the HCL calls for the production of *relevant* community health solutions, an outcome that is only possible through the utilisation of an all-encompassing community-centred lens. Further, the potential to build strong community connections and partnerships is undeniably reliant on the social and self-awareness of the relationship initiators. Ultimately, the need for an examination of the self, a way of determining one's

social location in relation to biases, assumptions, power and privilege, was administered through the utilisation of human-centred design thinking.

As mentioned before, the human-centred design approach entails the application of five distinct, yet fluid dimensions: empathise, define, ideate, prototype and test. This approach opens unique doors to problem-solving, by pushing the constant definition and *re*definition of problems, the extensive understanding of, and empathising with, community members and the consistent development and refinement of ideas, prototypes and tests (Ardiles et al., 2021). In essence, this approach is designed to stimulate a deeper understanding of a problem by guiding users to identify and define a problem, analyse the origins of the problem and understand how implicit biases shape one's perception of the problem. The human-centred design approach was incorporated within the HCL teaching since its conception in 2015, up until 2018, with a shift to a new model of equity-centred design that was an iteration of Stanford d.school's design thinking process (Pinedo, 2020). The equity-centred design approach, also known as Liberatory Design, was co-created in 2016/2017 as a collaboration between Tania Anaissie, David Clifford, Susie Wise, and the National Equity Project [Victor Cary and Tom Malarkey] in the US (Anaissie et al., 2021).

The progression towards an equity-centred design approach was gradual and fluid and was made following the demand for a more ethical and equitable perspective to health promotion and community engagement. Each iteration of the HCL exemplified a need for an effective and constructive means of building community relationships, understanding ethical perspectives and communicating relevant solutions, and so, the existing human-centred design approach was expanded. The equity-centred model is, basically, an extension of the human-centred model through the addition of two key dimensions: notice and reflect that are critical for self-reflection and understanding the complexity of problems. To facilitate co-creation of solutions that are community driven, Liberatory Design (Anaissie et al., 2021) is fluid and emergent process across these seven stages, as described below:

- *Notice:* The notice phase is tactfully positioned at the start to ensure that equity is a guiding principle of the design process. In this phase, designers are encouraged to position themselves within the context of the problem, to identify their own biases and assumptions and to reflect on their social location, identity and underlying values. The placement of 'notice' at the beginning of the design process emphasises the user and the community and allows for the creation of user-centred solutions, as opposed to designer-centred ones.
- *Empathise*: The empathise stage is essential within community engagement and collaboration. This phase highlights the need for active listening and open dialogue. By empathising, designers are able to grasp a better understanding of the lived and living experiences of the users and are also able to gather significant insights and opinions.
- *Define*: The define phase is important in ensuring that the design direction is distinct and realistic. After taking into consideration the contributions of the users, this phase allows designers to narrow in on a concrete problem area.

- *Ideate*: The ideate phase involves generating applicable, relevant solutions based on the feedback and insights of the users. This phase is dependent on the overlapping themes of the 'notice', 'empathise' and 'define' phases.
- *Prototype*: The prototype phase entails the modelling of a tangible solution for the user test.
- *Test*: The test phase creates a space for honest feedback and criticism. Within this phase, users share their experience with the prototype giving key insight into the feasibility, applicability and sustainability of the design.
- *Reflect*: The reflect phase is pivotal to personal development and self-reflection. Within this phase, designers recollect varying experiences, lessons and milestones across the design process and gain a better understanding of their growth and development (Anaissie et al., 2021).

The iteration and reiteration of the equity-centred design process ensure that the identified problem areas are not subjected to the traditional, impractical top-down community solutions. Particularly, the 'notice' and 'reflect' phases drive a deeper understanding of the self, allowing for students to identify and dismantle their own biases and assumptions and put themselves in the shoes of community members. Equity-centred design creates ample space for a critical examination of the self and directs individuals to discern the ways in which varying systemic dimensions of history, power and privilege shape how they, in relation to different communities, experience comparable events. Ultimately, the use of equity-centred design generates a holistic, in-depth perception of the community, leading to the development of innovative and applicable user-centred interventions.

Conclusion

The Health Change Lab, an innovative health promotion pedagogy, serves as a model for future applied health promotion initiatives. Within a global context, the general form and foundations of the program can be fluidly reconstructed and adapted to match infinite situations and settings. However, regardless of the location and/or learning medium, the core experiential and community-engaged nature of the program ensures that the solutions proposed are uniquely catered towards the community of interest.

Due to the ongoing COVID-19 pandemic, most, if not all, forms of education have been forced to adapt to the constraints of virtual learning. While experiential education and community engagement are often considered synonymous with tangible community participation, the shift to online mediums has showcased their adaptability to varying contexts. Despite the challenges that emerge alongside the isolated nature of online learning, it is important to recognise that community relationships and agreements can continue to be built and cultivated through virtual mediums. Ultimately, by using relevant guiding frameworks and methodologies, like systems thinking, community engagement, multisectoral collaboration and

Table 41.1 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Our vision for health promotion is to produce professionals that are equipped with the skills to holistically tackle community health challenges. In order to move past deficit-based health promotions strategies, and as a way of diversifying health promotion pedagogy, the Health change lab is an experiential, intersectoral, transdisciplinary program
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	The program is intersectoral, including students and instructors from multiple disciplines, and a collaboration between the local health authority, the city of Surrey and various community-based non-for-profits. It is a 13-week, three-course, 10-credit program
Which theories and methodologies are used in the teaching-learning process?	Multiple theories and methodologies are used in the teaching-learning process, including human/equity-centred design, systems thinking, community engagement theory, social innovation theory and transdisciplinary and interdisciplinary approaches. The theories and methodologies used Endeavour to optimise students' understanding of context, history and community challenges, while simultaneously advancing community collaboration, co-design and knowledge transfers
What forms of assessment are applied, results achieved and challenges faced?	There is a diverse range of assessments used to evaluate the growth and development of each student, including reflections, presentations and reviews; the assessments are split into two components, individual and team-based. The results pertain to the growth of each individual student, through the acquisition of systems thinking, transdisciplinary and interdisciplinary perspectives, an understanding of equity-centred design as well as various skill development (leadership, public speaking, collaborating, etc.). Community benefits include the development of relevant solutions to health problems. Challenges include the time constraints of the Health change lab program, as well as obstacles faced when placing students within a community setting
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning?	The Health change lab program is guided by various principles and approaches, including the eight ethical principles of community-engaged research/education, multisectoral collaboration, equity-centred design and systems thinking. Essentially, this program endeavours to provide students with a holistic understanding of health and the skills to develop relevant community solutions
What others could learn with your experience? What is localised and what is 'generalisable'?	As an innovative health promotion pedagogy, the frameworks and methodologies used in the Health change lab program can function as a foundation and inspiration for future health promotion designs. The general design of the program enables knowledge transfers between students, instructors, stakeholders and community members. Within a general, global context, the overall structure of the programs can be recreated and adjusted to match any environment. In terms of the local, the experiential nature of the program ensures that the solutions proposed are uniquely catered to the community of interest

equity-centred design thinking, experiential health promotion pedagogies can be successfully managed and delivered remotely. By centring the lived and living experiences of users at the core of the design process, equity-centred design thinking enables students to acutely identify their own biases, identities and assumptions (Pinedo, 2020). Further, with the idea of attention to context in mind, the ever-changing present conditions can help bring to light neglected community problems and simultaneously reveal the new and emerging community health challenges. The extensive and ongoing examination of power and privilege, in conjunction with co-creation of solutions with community partners, can contribute to advancing anti-racist and anti-oppression pedagogy, critical for the future of health promotion in a post-pandemic recovery scenario.

Table 41.1 brings our reflection on the six triggering questions suggested by the editors.

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Chapter 42
Health Promotion in the Region of the Americas: An Educational Innovation Proposal

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Contents

Introduction

The collective work "Health Promotion in the Region of the Americas" (hereinafter HP-RA) is a collaborative process that opens up opportunities for knowledge building and the development of skills, resources, and commitments, collaboratively building health education tools. Tools are put at the service of the interested parties that open up spaces of possibility and lifelong learning, with the certainty that, if a multiplier power is achieved at the level of

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collaborative networking and processes, significant changes in health care that can be managed in a co-responsible manner will be advanced beyond the limits imposed by disciplinary or country borders.

We start from a context analysis in which the collective work is born considering the challenges that arise from it; we present conceptual proposals, stages of progress of the collaborative process, learning and results obtained; we describe in detail the path traveled and methodologies for collective construction, and we present it considering that a useful experience, replicable, that provides interesting elements for the construction and strengthening of capacity in health promotion can be a benchmark for proposing collaborative processes between countries that contribute to necessary cultural transformations for health and quality of life.

Context

We were born and live by assuming as natural a development model centered on the freedom of markets and the unlimited consumption of the resources fundamental to life, private property, and individualism: a cannibal capitalism that destroys life forms and opportunities for a good and quality life in conditions of equity. Not only "social injustice is killing a lot of people," as stated in the report of the DSS Commission (WHO Commission on Social Determinants of Health, 2009, pg.26), instead, we are used to seeing as spectators how ecosystems are destroyed and the possibility of quality of life is devoured in the present and for future generations.

The pandemic in 2020 is an unheard voice of alarm. Those forms of relationship with ourselves, with others, and with nature emerge as natural, anesthetize us, and make us feel powerless and fearful. In the context of a pandemic, some individualism and control alternatives over the majority are strengthened while inequities not only prevail but are exacerbated as "deeply unequal vulnerability among people" (Akerman & Rodrigues Pinheiro, 2020).

In this context, biologic models also prevail, with consequences ranging from how health and disease are understood and managed to the expected and achieved extent derived from strategies designed to address the global crisis caused by the pandemic. The strategies that are designed and the expected accomplishments are limited to managing or trying to prevent diseases, in an ineffectively way. Noncommunicable diseases increase, the duration of human life, although they have increased, was not accompanied by quality of life. Today, the COVID-19 kills the most vulnerable population. We understand that inequalities are unjust and avoidable, but we get used to them, reproduce them, and pass them from generation to generation as consequences of the prevailing development model.

We know that health is more than the absence of disease, but the human being is fragmented, starting with the training of health professionals, ignoring an integral vision, and subtracting importance to the social, cultural, and psychological issues. Health services are actually disease services, in which fragmented perception leads to treatments more focused on medicines that relieve symptoms than processes based on diagnoses and comprehensive understandings of individuals and groups, to lead them to regain their health, and to empower themselves to stay healthy and contribute to the health of others.

In practice, promotion and prevention are spoken of as synonyms, but real skills are not developed to manage processes from logic of promoting emancipatory health and to bring together efforts to build indispensable cultural transformations in favor of health and life.

In this historical time, when one would expect the building of health possibilities to go beyond the care of the disease, the effort remains in prescriptive, hygienist, and control measures and acts as if not actually being infected were equivalent to being healthy. Decision-makers are trapped in dilemmas that move them between prevention and the economy, where usually prevails the logic in which equity, quality of life, good life, and good living are utopias for most people.

In the training of health professionals, the biomedical model prevails and it is assumed that professionals from other disciplines do not need to understand what health is, what health promotion is, and less to be active in their management. Since the movement of health promotion universities, it is clear that training in health promotion is to be transversely developed, but there is no progress in this direction with the necessary force to build dialog with the local, with the community, with other knowledge traditionally not legitimized from academia. It does not advance in reflections on practices and their effects on collective health or on life itself nor does it advance sufficiently in the articulation of efforts and comprehensive and integrative approaches that add perspectives and look at experiences, assets, and learning. "We need to reflect on the sense of our intentions and practices in health" (Chapela & Alasino, 2020, pg.4) and to train health professionals and professionals in general, so that all of them and all of us are able to connect with the senses of our work and recognize the need to build broader visions that consider socioeconomic inequality and the indirect effects of the pandemic and let us work to position the contribution from participatory models and asset-based community management in which strategies are built with people taking advantage of their knowledge and resources.

The challenges arising from the direct and indirect effects of the pandemic raise the need to innovate in the training of professionals in all areas and in the way health is managed and promoted, so in the face of this reality, from the Health Promotion Network in the Region of the Americas. It aims to contribute to generating proposals and resources that add to existing ones and open up new possibilities of knowledge relationship among key actors and among leaders in health promotion in the region in order to create a community around the topic of promotion of health.

Presentation of the Collaborative Process Features, Achievements, and Learnings

History

The collective work Health Promotion in the Region of the Americas – HP-RA Toolbox – begins in 2019 in the framework of the IX Congress of the Ibero-American Network of Universities Promoting Health (RIUPS). It begins with 70 experts from 14 countries of the Region of the Americas, who work for health in their countries, from different settings. The coauthors belong to different disciplines related to health sciences, social and human sciences, and areas related to the conservation of natural resources and environmental care. The construction and continuity of this initiative require the formalization of spaces for dialog and reflection on perspectives and experiences aimed at contributing to the strengthening of capacity to promote health.

The process begins in 2019, and the launch of the collective work took place in July 2020, in this same month the interactive spaces started with a biweekly periodicity. The platform and social networks are constantly updated.

This work presents different alternatives to contribute to capacity building in health promotion. It seeks to introduce new resources and learning methodologies, contributing to the development of skills and to the formalization of synergies, to assume correspondingly the revitalization of health promotion, in response to the current historical moment of global involvement by the COVID-19 and improve existing learning around the most efficient ways to manage health from a concept linked to quality of life, human development, participation, and well-being.

The initiative development is guided by some questions that serve as a guide to achieving the objectives, for example: How to manage a collaborative process at the regional level? What strategies can promote encounter, interaction, formalization of synergies and lead to other new collaborative processes? How can virtuality be an opportunity for the project to recover and use health-promoting learnings, experiences, and opportunities in the region?

This work has advanced in stages that have involved achievements and give rise to opportunities and challenges that allow the consolidation of a living process. In it, self-observation, reflection, problematization, capacity building, complement, and expansion of perspectives are possible.

For example, the launch of the work with the support of the Pan American Health Organization positions it as a toolbox at the service of those interested in the topic, and it seeks to contribute to the *Strategy and Plan of Action for Health Promotion in the Context of the Sustainable Development Goals 2019–2030*. The publication of the platform opens up opportunities to achieve complementarity between the resources and experiences that are part of the collaborative process and at the same time is a tool in itself, as it allows to publish the contributions received and project the process, leading to the initiation of the interactive spaces.

The process has been developed in three stages that made its consolidation and projection possible.

The first stage involved the construction of the structure that would guide the progress of the collective work with shared criteria. In the second stage, emerging information was retrieved from collective production to perform content and information analysis. In the third stage, based on the experience experienced, the analysis of the content of the information recovered is carried out, progress is made in the construction of methodologies for monitoring, and evaluation provides inputs to project the next stages of the collaborative process. Table 42.1 presents the schedule and the actions that allow the collective work to be initiated and the progress in its elaboration, publication, and dissemination.

First stage: Construction of the structure that guides the progress of the collective work with shared criteria This consolidated a team and operational dynamics that favor collective construction, defined a timetable for progress, and established criteria for the elaboration of the articles part of the collective work.

Second stage: Implementation and analysis of content and emerging information in interactive spaces At this stage, interactive spaces are launched and thus the dissemination and divulgation of information and reflections recorded in the first stage are encouraged. Work is being done to achieve a permanent update and manage support for positioning the platform on the social networks of its own and allies.

A guide for the analysis of emerging information is developed, interactive spaces (forums-experiences) are transcribed, and information that constitutes an input to project the process is analyzed.

Third stage: Consolidation and projections The collaborative process and collective work are positioned as a valuable toolbox for capacity building in health promotion in the region.

Retrieved information (articles, shared experiences, forums) provides important elements to advance the revitalization of health promotion in the region in the framework of the implementation of the *Strategy and Plan of Action for Health Promotion in the Context of the Sustainable Development Goals 2019–2030*.

The third stage is defined on the basis of the information retrieved and is planned as a living process managed jointly from different countries of the region, and these new perspectives are recognized that contribute to the construction of new ways of working for health.

It is a nonprofit process built with full confidence in the contributions of collaborative processes, health promotion, and the strengthening of the collective as an alternative for building possibilities for health and quality of life in conditions of equity.

It seeks to validate other forms of publication of knowledge at the service of people, understanding knowledge as a dynamic process that is built in the dialog between experience and clear conceptualizations, recognizing the importance of continuous learning that feeds from different perspectives and readings. Knowledge belongs to everyone and should be at the service of everyone. It also seeks to advance the mobilizations that we proposed in the article of release of the work and which are presented in Table 42.2.

Table 42.1 Stage actions

Definition of objectives, agenda, people in charge, and schedule	Formation of an interdisciplinary and intercountry team
	Definition of objectives, agenda, people in charge, and timetable
	Common criteria for drafting chapters
Elaboration of the collective work and implementation	Brainstorming keywords in each of the questions: chapters
	Presentation of chapter outlines
	Text elaboration: first draft Peer review and suggestions: cross-checking of chapters by pairs of author teams
	Presentation of draft: peer reviewers
	Adjustments to texts
	Review of citations and bibliography for each chapter
	Style correction Layout: graph and table design
	Presentation to the general team of the chapters for review and final suggestions
	General review of the publication. Web platform
	Publication of platform and socialization of mechanisms for sending contributions to the virtual library
	Feedback and final adjustments of the completed work
	Layout of virtual and physical formats
	Evaluation of the elaboration process and suggestions (learning for future collaborative processes)
Dissemination process	Registration of the experience
	Dissemination: collaborating centers, PAHO representative offices, RIUPS colleagues and other UPS networks, UPS national networks, RIUPS commissions, social networks. Networks: municipalities, schools, organizations, key actors in the countries. YouTube channel, Facebook of the work
	Elaboration of an article in Spanish about the experience synergies and collaborative processes: an educational innovation from health promotion
	Translation of the article in Spanish about the experience. Synergies and collaborative processes: an educational innovation from health promotion
Monitoring and evaluation	Alliance with CEDETES. Elaboration of guidelines, development of instrument, periodicity, application, analysis, and reports
Implementation of interactive spaces: forums and presentation of experiences	Schedule
	Preparation with each team
	Partnership with CEPEDOC for the realization of interactive spaces. Forums and presentation of experiences in the region
	Production: recording
	Transcription
	Content analysis
	Revision by each author team: adjustments
	Publication of transcripts and content analysis

Table 42.2 Synthesis of opportunities toward important transformations in favor of health promotion

From (best-known and traveled roads)	Toward (opportunities in the framework of health promotion)
Assume static knowledge that is learned, transmitted, reproduced, applied, and published	Assess *dynamic knowledge* that is built on the dialog between experience and clear conceptualizations. Recognize the importance of continuous learning that feeds on diverse perspectives and readings
Vertical relationships: expert knowledge that allows to diagnose and intervene	Changes in the way we relate: *horizontal relations*, complementary knowledge, and other valuable and necessary forms of knowledge, which give rise to interactions in which mutual recognition, co-responsibility, and real possibilities for co-producing health prevail
Fragmentations and control alternatives to study reality. Classify, intervene, and manage risks	*Comprehensive, dialogical readings*, ready to contribute to necessary transformations. Map assets, accompany and facilitate participatory processes
Academic production from other regions is assumed as the only benchmark for quality	Recover, visible and share disseminate appropriate knowledge built in the region from our particularities in countries, municipalities, localities, and environments in Latin America and the Region of the Americas
Idealize publishing only in scientific journals, being read by other academics, and make our production better evaluated	Promote *other means and other public and open access alternatives with quality information*. Open possibilities of autonomous linking between authors and stakeholders in the topics to learn how to contribute and build with others
Search for truth, certainties, and formulas	Recognize the importance of understanding, enjoying and valuing uncertainty; the existence of diverse perspectives, readings and truths, all important to understanding more integrally *dynamic realities*
Economic resources seen as a prerequisite for initiating processes	Certain that *starting from existing assets and resources* can promote synergies in powerful processes, deeply connected with people and contexts. To recognize that community participation and asset management favor co-responsibility, collective visions, and empowerment and that economic resources can facilitate, complement, and enhance a community's assets, but they alone do not guarantee collaborative processes or are a prerequisite for achieving them
"P and p" (promotion and prevention) undertaken as the same effort	Clear differentiation of the specificities, methodologies, and possible achievements in a clear commitment *to promote health from all settings, favoring synergistic processes between them.* Processes that lead to health promotion, recognizing that we are all ethical subjects capable of building and giving value and meaning to our action
Devour, consume, and destroy resources and the planet	Awareness of the global and particular consequences of the destruction of natural resources. *Construction of new development models* and new modes of production, which favor sustainable individual and community well-being. Work collaboratively to contribute to cultural transformations needed for health and life

Table 42.3 Types and forms of relationship and possible outcomes

Vertical relationships: working for people	Horizontal relationships: building with people
Something prescriptive on a mandatory level	Something we are co-responsible for
Risk of reinforcing mistrust	Strengthen solidarity
Let the population listen	Interest in promoting participation and giving voice in the construction of solutions
Sanction. Use of force: arbitrariness, totalitarianism, loss of rights	Results resulting from collective work: solidarity collaboration, self-care, mutual care, resource care, commitment to health and life

Participants

The linkage of key players allowed them to have the human and professional resources necessary to project the collective work (see Table 42.3). This work is carried out with the participation of experts linked to different environments, state entities, universities, PAHO collaborating centers, and more than 70 experts from Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, Peru, Costa Rica, Ecuador, Spain, Mexico, Puerto Rico, Uruguay, and Portugal. A team of authors is formed that organize themselves to open reflective spaces in which they dialog theory and experience, and new documents are built with a pedagogical character that contributes to the strengthening of capacity in health promotion. Intercountry teams are organized to address issues considered important to respond to emerging needs in the context of the pandemic.

Current Work

This bet seeks to collaboratively build responses to the need to understand and apply in our practices what the salutogenic models, intersectorality, the collective, the co-production of health, the co-responsibility and, take critical positions to fully understand the problems that affect health and collectively build alternative solutions. We assume that we do not need to return to a normality that was hurting us nor does it make sense to wait to see what a new normal brings us by inertia, but we need to build other ways of relating ourselves to opportunities for human development and for a good life in conditions of equity. We are sure that health promotion is an alternative to promoting community development, synergies, and networking and an opportunity in the current context to learn how to manage assets and recognize the value of other knowledge, giving value to the intercultural, to the interdisciplinary, and to the collective.

The Pan American Health Organization Regional Office in Washington participates permanently from a synergistic relationship that makes it possible for the

collective work to retain autonomy in the management of the process and information and to contribute to the revitalization of health promotion in the region, in line with the *Strategy and Plan of Action for Health Promotion in the Context of the Sustainable Development Goals 2019–2030*, adopted by the 57th Directing Council of the Pan American Health Organization (PAHO), as a call for health and welfare interventions to move from emphasizing individual behavior to addressing a broader range of social and environmental measures.

The Collaborating Centers of the Pan American Health Organization are linked with the initiative by collaborating with articles and offering specific support for the process (CEPEDOC, virtual rooms for interactive spaces; CEDETES, process monitoring and evaluation; CIPSES and PROINAPSA, authors of article and corresponding forum).

Reflective spaces are innovative and powerful as a possibility of encounter and permanent exchange. As Rivas (Rivas Navarro, 2000) proposes, this is important because:

"The analysis of one's experience and the reflection on it, enriched by the processing of diverse information, produces change of concepts, modification of preconceptions and prejudices. It generates conceptual restructurings and new cognitive schemes, as the foundation of new visions, renewed personal educational theories and more operational teaching models. It is the basis for the development of teacher knowledge and skills that are consolidated and functional in the interaction between the teacher and the school environment in which he or she exercises his or her professional tasks" (pg,292).

The reflective processes that occur in the interactive spaces, in the analysis of content of each topic and considering the parts of the work, allow to expand the initial perspectives and conceptualizations and achieve more complex understandings of the realities that are addressed, innovative and living processes.

In the same way, interactive spaces (forums and presentation of experiences) make it possible to formalize opportunities for the reflection and knowledge building, the complement of knowledge, and the identification of health needs and assets. In addition, they allow the initial team of authors to open up to dialog with other stakeholders and share experiences on the subject. The subsequent analysis of emerging information allows for greater depth of reflection and project the process considering the identified needs, resources, and challenges. This information is retrieved considering the following concepts:

- *Assets and resources:* "factor or resource, which enhances the capacity of individuals, communities or populations to maintain health and well-being" (Morgan & Ziglio, 2010, p.13).
- *Strength ideas and emerging reflections*: approaches of the speakers and in the chat in the framework of reflection.
- *Needs and challenges:* identified within the framework of reflections.
- *Opportunities:* situations, contexts, conditions, and experiences that can promote developments on the subject identified within the framework of reflections.

The interactive spaces for the years 2020 and 2021 were programed with the team of authors, and conditions were raised to favor a co-responsibility that makes possible the realization of interactive spaces with a biweekly periodicity.

The work is initially composed of 29 articles prepared by the participants from 14 countries and thus is organized a timetable in which it is formalized that each team will be in charge of the forum to the article of their authorship and it is defined a fortnightly space for each topic addressed in the items produced. Spaces are also planned to share experiences on the topics addressed in the forums.

The greatest contribution of the interactive spaces is the possibility of exchanging perspectives and reflections, appropriating learning, and strengthening the capacity to manage process at the local level. The main levels of participation identified are presented in the following chart.

Why It Is Innovative

We start in this sense from the concept of innovation as "an action that involves the process of incorporating something new into an existing reality, modifying its being and its operation, so that its effects are improved" (Rivas Navarro, 2000, pg.25).

We consider HP-RA as an experience of educational innovation since its process of construction and implementation shows that it is possible to mobilize from known paths, learning, and previous experiences toward more powerful forms of relationship between key actors, opening possibilities for renewing concepts, strategies, and expected and achieved achievements.

The collective work, moreover, allows the recovery of learning derived from emerging information and shows that collaborative processes are living processes that, being understood and projected correspondingly, open up new opportunities to manage health and well-being in diverse contexts from comprehensive global views and in connection with the local.

This is how this project seeks to respond to needs that relate to the objectives that guide the process:

- To contribute to capacity building in health promotion.
- Build new knowledge from the dialog between theory and experience and put it at the service of health promotion stakeholders.
- Encourage agile access to quality information.
- Open spaces that make possible reflection, learning recovery, and dialog among stakeholders in the Region of the Americas on issues related to health promotion.
- Make visible key players in the region who can contribute to building necessary advances at the level of health promotion.

The novel elements are also related to facilitating democratic access to quality information on a platform open to the service of all stakeholders and opening opportunities for reflective moments in interactive spaces by continuously generating new information and knowledge on the topics addressed. It is a living process that is continuously fed by authors and users.

The work could be cataloged as an input as an innovation concerning the procedure of "using curricular materials and teaching tools as support for the development of the contents" (Rivas Navarro, 2000, pg. 53). The platform includes academic production existing on the subject in the virtual library and articles prepared for the collective work that bring new reflections and knowledge organized in the parts of the HP-RA built with the purpose that gives rise to its birth.

Results

We present the results of the first phases of the collaborative process (HP-RA), organized into three categories: those related to the consolidation of a structure that makes the process possible, those referring to the organization, and those that realize its continuity.

Results Related to the Structure and Organization of the Process

- Linking key actors from 14 countries of the region interested in contributing to a collective work: In 2019, in the framework of the IX Congress of the Ibero-American Network of Health-Promoting Universities, in a meeting attended by representatives of the National Networks of Health-Promoting Universities and the representative of the Pan-American Health Organization, it is identified as a necessity for the region to build strategies that contribute to the strengthening of health and put to the service of the interested knowledge, experiences, and learning. Subsequent virtual meetings define a content structure that is developed from work teams and results in articles with new academic production built for collective work with shared criteria.
- Academic production: Five parts are proposed to guide it, each having a minimum of four articles in which the topic is deepened by putting theory and experience into dialog (see Table 42.4). These parts are as follows: Part 1 – historical and current background, currents of thought in the promotion of health in the region of the Americas; Part 2 – dominant and emerging perspectives and operational frameworks for health promotion; Part 3 – components to strengthen health promotion processes and practices; Part 4 – scenarios and environments promoting health in everyday life; and Part 5 – challenges and opportunities of health promotion.

Table 42.4 Structure of collective work

Part 1 **Historical and current background: currents of thought in health promotion in the region of the Americas** **Articles**	**Part 2** **Perspectives and dominant and emerging operational frameworks of health promotion** **Articles**	**Part 3** **Components to strengthen health promotion processes and practices** **Articles**	**Part 4** **Health-promoting scenarios and environments in everyday life** **Articles**	**Part 5** **Challenges and opportunities for health promotion** **Articles**
The health promotions we do Health: A Look at Your Socio-Historic Promotion and Determination Equity and Health Promotion The right to health and health promotion: an instrumental binomial to protect the dignity of the person Promoting Health and Development: A Critical Vision from The Sustainable Development Goals Climate change and health promotion	Linking governance and health policy advocacy Role of universities in generating public policies for health promotion Concepts and perspectives of Health Education and Health Promotion in Times of Pandemic Careers in Life Skills, Human Development and Health Promotion in the twenty-first Century	Learnings related to the Health Promotion Assessment Information and Communication Technologies and Health Promotion: Scopes, Experiences, and Challenges Participatory models: Key players in health promotion Human Talent/Human Resources Training in PS/PS Specialization Contributions to health promotion from medical-innovated curriculums: experience in Argentina Undergraduate training in medicine suitable for the implementation of the Comprehensive Health Care Model since the 2017 Human Resources in Health Strategy Collaborative and networked work in the Promotion of Health Dimension of sociocultural studies in health promotion in the context of the Region of the Americas Health assets from the winds of Latin America Investigation in the practice of health promotion: Lessons learned for the health sector in Mexico	Healthy cities and municipalities Citizen Organizations – Health Promotion: with whom and where? The School as an Environment to Promote Health: Latin American Experience Universities Promoting Health Healthy Work	What would be the attributes for intersectorality in the twenty-first century? In search of a next-generation intersectorality Communication for development and for change challenges in health promotion Global health and health promotion challenges in the Region of the Americas Epistemological challenges and action in the field of Health Promotion

Offer of Health Promotion Resources

Publicación y lanzamiento de la obra colectiva en la sala promoción de la Salud OPS Oficina Regional Washington 15 julio 2020.[1]

Permanent interactive spaces with a fortnightly periodicity. Participants from different countries in the Region. Recording, publishing, transcription, content analysis.[2]

Specialized Virtual Library that is permanently updated.[3]

Strategies to Promote Access to Information for Different Target Audiences in Different Media

Facebook page. Visits and reach of Facebook posts.[4]

Virtual Platform.[5]

Process Email as a communication channel. Receipt of requests for advice, conferences and accompaniment to ongoing processes.[6]

documentation of the entire process and formalization of the possibility of freely accessing all the information recovered.[7]

Continuity of the Collaborative Process

The intercountry team remains active after the launch of the collective work. The authors participate correspondingly in the development of interactive forums and spaces and in the making of decisions related to the progress and projection of the process.

Thanks to the positioning of the collective work, coauthors are invited to participate as co-organizers of international events, such as the international events organized by the Peruvian Network UPS, CEDETES, University of Costa Rica in 2020.

Requests are received from lecturers from the authors' team for international events related to health topics organized from Colombia, Mexico, and Costa Rica in 2020 and for training spaces, such as presentation of the platform to students of the PhD Public Health Puerto Rico.

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[1] https://www.promocionsaludregionamericas.com/

[2] https://www.promocionsaludregionamericas.com/foros

[3] https://www.promocionsaludregionamericas.com/biblioteca-virtual

[4] https://www.facebook.com/CAJAHERRAMIENTASPROMOCIONSALUD

[5] https://www.promocionsaludregionamericas.com/

[6] https://www.promocionsaludregionamericas.com/

[7] https://www.promocionsaludregionamericas.com/

In order to promote continuity, the importance of the recovery and analysis of emerging information is raised and of taking evaluation and monitoring as an important part of the process and of taking input in the timely decision-making when projecting the continuity of the process.

Documentation and Permanent Reflection on Achievements, Progress, and Difficulties

It is a process that progresses connected with the context, needs, and emerging information. We seek two-way communication with the team of authors, favoring co-responsibility, participation, the use of resources in the team, the recovery of learning, and the linking of new members.

Recovery and Analysis of Emerging Information

Content analysis of the information is retrieved in the interactive spaces (forums and presentation of experiences) based on a participative constructed guide with categories of analysis that account for relevant information to project the process.

Evaluation and monitoring as input are needed to make timely decisions to project it.

The methodology for evaluating the project is presented by the Center for the Development and Evaluation of Policies and Technologies in Public Health (CEDETES) of the School of Public Health of the Universidad del Valle, a PAHO collaborating center, and developed by Andrés H. Pérez Bustos and CEDETES. In this it is proposed to focus the evaluation on objectives 3 and 4 of Health Promotion in the Region of the Americas (HP-RA) and, specifically, on objective 1 of the interactive spaces of the collective work: "To offer those interested in health promotion meeting spaces that lead us to identify key actors and build communication bridges" (Granados Mendoza, 2020a, 2020b). It is proposed to make an evaluation of the capacity of HP-RA to build collaboration networks through the interaction of its participants, using the Social Network Analysis (ARS) methodology (Pérez Bustos & Mosquera Becerra, 2020).

The results account for the first stages of collaborative work and are retrieved analytically to favor replicability. The progress of the first stages has allowed us to recover the learning that is described below.

Learnings Derived from the Early Stages of the Collective Work

Perhaps the first learning arises from the commitment to orient the collaborative process by putting into practice the fundamental postulates of an empowering and emancipating health promotion. This option initially led us to clarity about the place from which the process was formulated, the way to link ourselves, the achievements, and the effects we wanted to achieve.

It was very powerful to work from a participatory model, with tools learned from asset-based management and to favor, from the process itself, participation, co-responsibility, health co-production, interdisciplinarity, and complement for the achievement of common objectives. In the management of collaborative processes, the importance of conceptual and epistemological clarity as a basis for the design of strategies, methodologies, and interventions related to health promotion becomes evident.

Figure 42.1 shows the conceptual proposal.

We were able to show that we not only contribute but that teamwork and the openness to reflect and build together were also constituted in a learning space for the authors who found in the perspectives of colleagues the dialog, the theory, the experience, and the connection with diverse realities and possibilities for lifelong learning.

The interactive spaces were essential for the recovery of perspectives, experiences, and knowledge. The publication of recordings and transcripts, in addition to being evidence of their realization, makes permanent production and resources available to all interested parties that can be resumed and used freely. The contribution derived from reflective processes in intercountry teams is an opportunity for the construction of knowledge and learning related to diverse experiences. See Fig. 42.2.

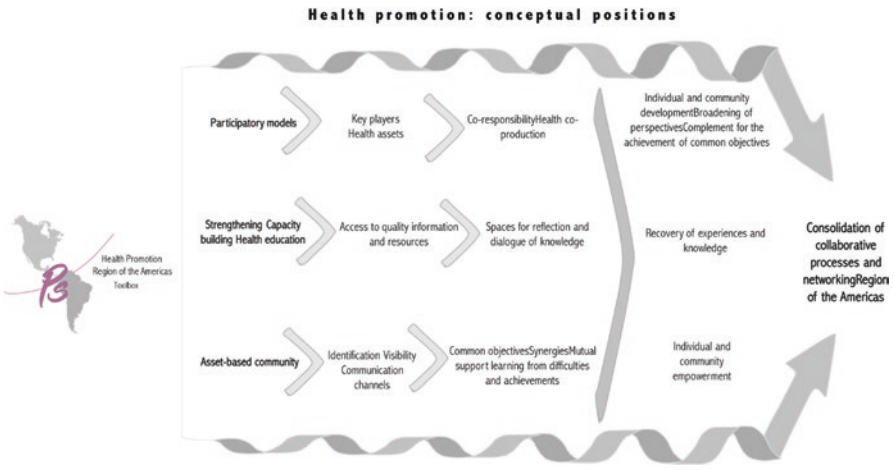

Fig. 42.1 Conceptual proposal (prepared by the author)

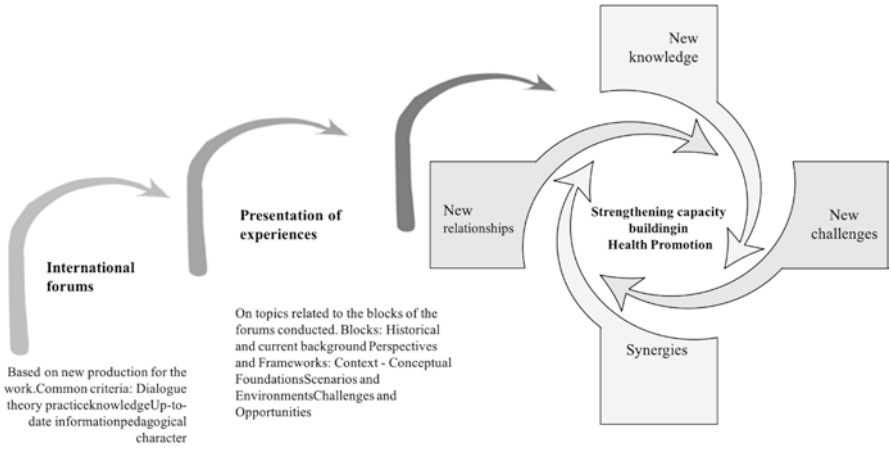

Fig. 42.2 Interactive spaces and their contribution. (Prepared by the author)

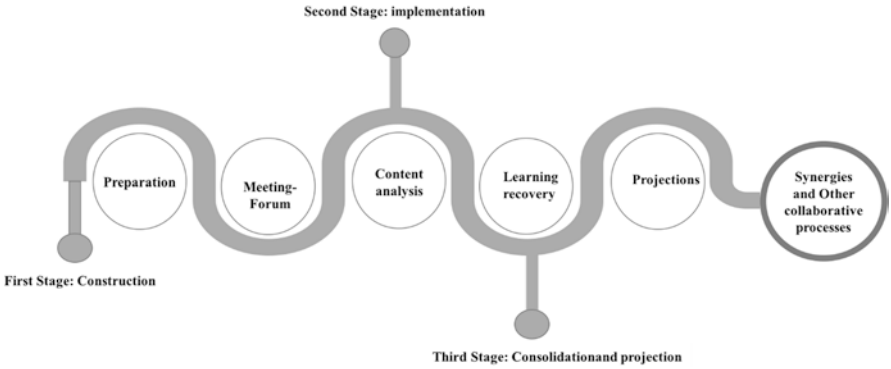

Fig. 42.3 Stages and moments part of the process. (Prepared by the author)

Free access to information is recognized as the basis for promoting collaborative processes and networking. The platform and the virtual library in this sense are the resources that favor democratic access to information for this work. The platform is permanently fed with the contributions received not only from authors but also from other stakeholders in health promotion and experts on the topics included in them.

It was evidenced that interdisciplinary and interculturality are essential to achieve comprehensive understandings of situations related to individual and community health. In the collaborative process, this is possible thanks to the characteristics of the intercountry team that brings together experts from different professions, linked to different environments and with a work relationship that includes state entities and academia. See Fig. 42.3.

Conclusions

The strategies aimed at educating for health must strengthen individual and collective capacities in the management of processes in which co-responsibility is experienced and appropriated as a form of relationship and work to achieve cultural transformations in favor of well-being, quality of life, and human development under conditions of equity.

In numerous world pronouncements, the great contribution of health promotion to the construction of possibilities for health and life is raised, but it is not formed to make it a reality. Only educational innovations that favor the construction of new knowledge, qualification of strategies, asset management, and development of collaborative and interdisciplinary processes from different environments will open possibilities for the consolidation and projection of advances aimed at achieving emancipatory possibilities in which individuals and communities become involved, strengthen, and find opportunities for their human development and for a good life at the individual and community level.

Managing this collaborative work at the regional level has implied recognizing that it is a living process, which advances connected with the context, needs, and emerging information, which permanently challenges us to open ourselves to weave knowledge, experiences, and learning, returning on emerging information and connecting with a changing and challenging reality such as the global pandemic that affects the world today.

Most of the efforts of the states, health services, and even many universities have focused on managing and preventing COVID-19 and adapting to build a new normal while preserving the functioning that prevailed before the pandemic. Efforts to find answers stand out from which they compete to find treatments or a purely biomedical solution that does not escape in addition to capitalist logic.

We also find powerful initiatives that are built from individual and community health perspectives and invite a broader vision, which encompasses education, employment, housing, food, and the environment, addressing noncommunicable diseases, inequities, and socioeconomic inequality. Our commitment joins other voices that call for structural changes and for the construction of development models based on real stakes for health and life.

It is an opportunity to work with leaders of the Latin American community health movement, academics, researchers, students, and community leaders, whose efforts open windows of possibility for other ways of being and being in the world. We feed our library on our site with links to these alternatives, which when joined will be powerful tools for social, individual, and community transformation. We are committed to building bridges and communication opportunities between social actors who believe that change is possible and health promotion is an opportunity to support it.

We have found that it is essential to open reflective spaces that give rise to synergies, support, and mutual learning and that, to achieve this, free access to information, platforms for dialog, and spaces to share experiences build knowledge and

open opportunities for the transformation of the realities involved from the possibility of opening up to mutual transformations.

Virtuality can become an opportunity to project the recovery and use of learning significant experiences in health promotion in the region when it is freely accessible and does not depend on resources mediated by those who hold the dominant powers, when it is permanently updated, when it is enriched with the contributions of those interested in the subject, and when the steps do not lead to goals to be conquered but to walk with others in the fascination of learning.

It is essential to promote more academic exercises and collaborative processes willing to publish not only in indexed journals for limited audiences with recognition in academic contexts but in other media, for different audiences, aiming to recover, make visible, disseminate, and appropriate knowledge built in the region to starting from our peculiarities and experiences. This makes it possible to promote democratic access to information by different audiences that may be jointly responsible for the production of health and life care.

The road is beginning. The collaborative process is born with the portal that lives thanks to the contributions we receive from the authors of the chapters and the experiences we share. It is the reflective spaces that lead to the platform being used, fed back, and permanently updated. We are certain that this collective product, built from joint responsibility, will be a valuable input for strengthening health promotion capacity in the Region of the Americas.

Table 42.5 brings our reflection on the six triggering questions suggested by the editors.

Table 42.5 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	In the current historical moment, health promotion should contribute to the construction of models of social and economic organization that favor present and future life in the practice. It should be linked to health concepts about quality of life, well-being, and human development that help to understand new possibilities to achieve a good life in conditions of equity. In this project, health promotion is a call for open opportunities to participate in decisions about people's life and community life, seeking to enable the dialog of knowledge from the local level. It faces challenges related to the clarity about the concept of health, the qualification of methodologies, and the systematization and dialog of experiences. These challenges are applied in actions and lead to a participatory construction of knowledge

(continued)

Table 42.5 (continued)

Questions	Take-home messages
What is the institutional and political context of your experience (participants, professions, and courses involved, duration, and frequency of activities)?	This collective work puts into practice the principles of an emancipatory health promotion and contributes to the strengthening of the capacity of all those interested in the subject. It favors the construction and democratic access to quality information and formalizes spaces for reflection and for the exchange of experiences. It is a living, dynamic process that is projected from a commitment to co-responsibility and participation for the construction of horizontal relationships and the building of synergies in favor of health and life. In this work, participating experts are linked to different environments, state entities, universities, and PAHO collaborating centers: more than 70 experts from Argentina, Bolivia, Brazil, Chile, Colombia, Cuba, Peru, Costa Rica, Ecuador, Spain, Mexico, Puerto Rico, Uruguay, and Portugal. The invited authors participate in biweekly interactive spaces that are offered to contribute to the construction of knowledge and the exchange of experiences. Those spaces provide materials and resources for permanent updating, which helps to strengthen the capacity in health promotion
Which theories and methodologies are used in the teaching-learning process?	The process is based on the concept of emancipatory health promotion, which refers to "the exercise and development of the healthy capacity of people and their collectives, expressed in epidemiological profiles that result in a more just, free, good, beautiful, and wise way of existing in society," from which it is essential to contribute to strengthening the capacity of people and communities as co-producers of health and co-responsible for the permanent improvement of the conditions that make health, well-being, and quality of life possible. The methodologies are related to the management of collaborative processes, thus leading to social dialog, recognition of knowledge, and recovery of experiences. To achieve this, access to information is guaranteed, and permanent opportunities for reflective processes are opened. The participation in the construction of knowledge is based on horizontal relationships built on deep respect for others, diversity, and particular worldviews
What forms of assessment are applied, results achieved, and challenges faced?	The project includes the recovery and analysis of the information retrieved in the interactive spaces; this work provides inputs for projecting the next stages of the collaborative process. Based on that, it is possible to understand the achievements, progress, and difficulties in order to follow and accomplish the goals. In a complementary manner, CEDETES Center for the Development and Evaluation of Policies and Technologies in Public Health (from the School of Public Health, Universidad del Valle, Colombia) proposes to evaluate the capacity of HP RA to build collaborative networks through the interaction of its participants, using the methodology of Social Network Analysis (SNA)
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	It is based on participation, co-responsibility, and empowerment, as it prioritizes the strengthening of individual and collective capacities, as well as the search for cultural changes necessary for health. This collective work opens opportunities for updating and exchange of experiences, favoring bidirectional communication between different audiences and users of the platform

(continued)

Table 42.5 (continued)

Questions	Take-home messages
What others could learn with your experience? What is localized and what is "generalizable"?	The methodologies and the work of recovery and analysis of information derived from the experience are replicable to manage collaborative processes and networking or generate resources that have sustainability and mobilize participation. The most significant learnings that others could appropriate are related to: Characteristics and opportunities for collaborative processes sustainable over time, networking, and participatory knowledge management. Documentation of processes, information analysis derived from meeting spaces, reflection, and dialog of experiences. The contributions from the toolboxes are fed participatively and freely and accessible as support for capacity building on a topic. The importance of writing articles for heterogeneous audiences with a pedagogical character in which dialog, theory, and experience favor the recovery of learning. The management of questions favoring collective construction processes. The importance of opening communication channels that favor synergies between different environments and key actors in the region. The importance of favoring the visibility of existing resources, the possibility of updating in real time, and the projection of collaborative and solidarity processes between countries.

Acknowledgments I express my appreciation to the authors and to all those who participate and will participate in this collaborative process, to the editorial committee, and to the team of authors whose active participation allows us to learn by building and to the wealth that comes from the commitment to work with others, to build communication bridges, dilute borders, and feel that we are the same region. The effort involved in forming teams from different countries generates new knowledge and reflections in which we weave diverse knowledge and experiences. The exercise of dreaming this product implies openness, dialog, mutual recognition, horizontal relationships, and co-responsibility. The work itself is an opportunity to co-produce health, to strengthen capacity, and to open spaces for participation for dialog, encounter, recovery of experiences, and permanent processes in which listening, reading, and sharing are a strength that enhances synergies and networking.

I thank all the coauthors of this collective work for the openness to build as a team to be co-responsible for the process. To PAHO for the accompaniment and permanent support, to CEPEDOC, a collaborating center of PAHO that supports the realization of interactive spaces, and to Ma. Isabel Ramírez, Coordinator of Educational Innovation of the Center for Learning, Teaching, and Evaluation CAE + E of the Pontificia Universidad Javeriana, Colombia, for their advice in the development of this article in which the work advanced as a product of educational innovation derived from teaching is recovered.

I invite those who believe in the commitment to health promotion as a way to work collaboratively to promote cultural transformations necessary for health and life, to participate in this shared dream, and to be health co-producers from the place of the region where his life passes.

Together, we can continue to innovate, transform the ways we interact, and produce new knowledge and opportunities to access it. We can take on health promotion work as a proposal that opens opportunities for each and every one of us to let ourselves be touched, transformed, and set out from known paths toward collaboratively discovering other alternatives that enhance development possibilities for others and for ourselves.

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Chapter 43
Sharing Paths and Converging Learning: A Consortium of Brazilian Health Promotion Graduate Programs

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Introduction

Brazil is a country with vulnerability situations perpetuated over time, and structural inequalities strongly impact people's health (Neri & Soares, 2002). It is fundamental to understand the interfaces of vulnerability and its direct relationship with the social determinants involved in the health-disease process (Barreto, 2017; Neri & Soares, 2002), especially in the context of the current pandemic of the new coronavirus, responsible for causing COVID-19 (de Albuquerque & Ribeiro, 2020; de Oliveira et al., 2020; Falquete et al., 2020).

The pandemic context has exacerbated gender, race, and income inequalities globally. Several environments started to experience troubling scenarios with the negative impacts, at different scales, on the health and economy of people and companies, resulting from other structural and cyclical problems concerning public health management (Hrynick et al., 2021; Kaye et al., 2020).

In Brazil, given the uncertainties regarding the best strategies to address the pandemic, the challenges were even more significant in the context of great social and demographic inequality, with unsafe housing, sanitation, and a high prevalence of chronic diseases (Barreto et al., 2020).

This global pandemic scenario then suggested the need to broaden the focus of health actions, emphasizing the social, physical, and economic determinants of people's well-being (Pronk et al., 2021). Thus, the concern arises to reinforce the paradigmatic shift from the biomedical model to a health promotion-based model that operates and builds interventions and strategies affecting the social determinants of the disease, such as poverty and social exclusion (Van den Broucke, 2020).

The pandemic has shown that it is essential to join effective efforts to build environments that can contribute to the health of the population (Van den Broucke, 2020). Thus, health promotion (HP) becomes essential because it fends for investments that recognize health and well-being as fundamental values: intersectionality, sustainability, empowerment and public participation, equity, and life cycle perspective (Nunes et al., 2020).

However, this movement to update the biomedical discourse, reinforcing the concern with collective contexts, is not new. It began in the late 1970s, with the health sector crisis, noticeable in the inability of institutionalized public health to control endemics and epidemics of that time (Buss et al., 2020; Raingruber, 2014).

Such reflections introduced the social issue as pertinent to medicine and health within academia and public management, which generated new demands for the training of personnel and the production of knowledge. Thus, postgraduate programs were mobilized to produce new resources for the research and training of masters and doctors with a new profile focused on public health concerns (de Souza, 2014).

Higher education has assumed a leading role since then. In this sense, we emphasize that universities have the specialized and technical knowledge and assume a privileged place in health education to formulate public policies and spearhead HP education. They are responsible for the production of knowledge and innovation

through education, research, and extension. They are also responsible for the training of professionals working directly in public and private health services and generally accessing the posts of health service management and institutional spaces for the formulation, inspection, and evaluation of public policies (Minowa et al., 2017).

It is part of the ethical and social role of education and research institutions to emphasize education that contributes to the health and well-being of the population. It expands the health dialogue and fosters this paradigmatic HP shift. Graduate courses committed to the HP framework and its interdisciplinary character were built in Brazil. These courses are fundamental for disseminating knowledge in the area and strengthening strategic actions in the country. Such programs assumed the responsibility to train professionals and researchers to address this complex field, which requires more than technical education but mainly adequate ethical posture in the face of social challenges (Andrade et al., 2020).

This chapter aimed to describe the establishment of a consortium between six postgraduate programs in health promotion in the Brazilian context. This institutional partnership offers HP training and is a strategy that provides spaces for reflections and dialogues on teaching and learning practices in the training of professional "health promoters" in contemporary society.

Unity in Diversity: HP from the Perspective of Graduate Programs

The HP framework results from increasing scientific production, whose concepts and practices were initially established at the International Conferences on HP, held in Ottawa (1986), Adelaide (1988), Sundsvall (1991), Jakarta (1997), Mexico (2000), Bangkok (2005), Nairobi (2009), Helsinki (2013), and Shanghai (2016) (Brasil and Ministério da Saúde, 2002; Heidmann et al., 2006). Other national and international contexts evidenced by the events and agendas such as the People's Summit, The Future We Want, People's Health Movement, Rio Political Declaration for the Social Determinants of Health, the Political Declaration of the UN General Assembly on Prevention and Control of Noncommunicable Diseases, Health in all Policies, Climate Change, Regional Consultation on the Strategy and Plan of Action for Health Promotion in the Context of the Sustainable Development Goals (2019–2030), and the Civil Society Working Group for the 2030 Agenda (GTSC) also contribute to HP actions.

The text of the Ottawa Charter (1986) remains a central reference for directing HP premises globally. This document identifies five fields of action: (1) building healthy public policies, (2) creating health-inductive environments, (3) developing personal skills, (4) strengthening community action, and (5) reorienting health services. The synergy between intersectoral action and healthy public policies is essential to promote health and mitigate inequalities. Subsequent global HP conferences by the World Health Organization (WHO) consolidated fundamental principles for

HP actions. In the documents produced, they reaffirmed that health should be the goal to be achieved by governments and the cornerstone of sustainable development. They also recognize health as a fundamental human right and equity in health as an expression of social justice.

In Brazil, HP has been discussed since re-democratization, emphasizing the Eighth National Health Conference, which was considered a milestone in the struggle for the universalization of the health system and the implementation of public policies in defense of life, incorporating the expanded concept of health as a factor resulting from ways of life, organization, and production in a given historical, social, and cultural context, associated with the creation of a National Health Promotion Policy (PNPS) established by Ordinance MS/GM n° 687, of March 30, 2006 (Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Secretaria de Atenção a Saúde, 2006).

In 2014, this policy was improved and updated and remained committed to addressing intra- and interregional inequalities, with the potential to strengthen the doctrinal and organizational principles of the Brazilian Unified Health System (SUS) and favor the promotion of equity (Rocha et al., 2014). Consolidation Ordinance No. 2, of September 28, 2017, consolidated the rules on national health policies within the SUS to legitimize the commitment of the Brazilian State with the expansion and qualification of HP actions in SUS services and management (Brasil and Ministério da Saúde, 2017).

PNPS is an essential public policy for coping with the population's difficulties, which is increasingly recognized by the different actors involved. In the study by Malta et al. (2014), the policy was analyzed regarding the implementation of priority management lines, highlighting the advances in the inclusion of HP programs in the budgetary programming, financing for municipalities and states for physical activity and body practice projects, significant advances in the surveillance of morbimortality and factors of risk and protection from chronic noncommunicable diseases, and advances in project evaluation, partnerships, human resources training, and social mobilization. The researchers also reported that the field of promotion is under a long process of construction, but steps are being taken for its institutionalization and strengthening (Malta et al., 2014).

PNPS points out that an important step to promote and strengthen HP in the country is to "promote specific education, professional training, and training processes in HP" (Brasil and Ministério da Saúde, 2014). However, the offering of professional and academic training courses in this area is limited in Brazil, and few specific specializations, masters, and doctoral courses are available in the field. The reference to HP appears more as cross-sectional knowledge within health programs and less as a specialty (Pinheiro et al., 2015).

The Coordination for the Improvement of Higher Education Personnel (CAPES), an agency of the Brazilian Ministry of Education, responsible for expanding and consolidating graduate courses in the country, identified this lack and encouraged higher education institutions the implementation of courses focused on HP. Brazil has six training centers at the postgraduate level, six of which are masters and three doctoral courses.

The University of Franca (UNIFRAN) proposed the first course in Brazil at the master's level in 1999 and the doctorate level in 2011. The Cesumar University (UNICESUMAR) started its inclusion in the field in 2011, and the program was authorized to offer the doctorate course in 2019. The University of Santa Cruz do Sul (UNISC) started the masters in 2010 and doctorates in 2019 in the field. The Adventist University Center of São Paulo (UNASP) has been developing the masters' course since 2013. The Lutheran University of Brazil (ULBRA) has had a masters' course in HP, human development, and society since 2018, and the University Center Guairacá (UNIGUAIRACÁ) started its masters in 2019.

Sharing Paths Between Graduate Programs: Interdisciplinarity on the Agenda

The establishment of a consortium between the six HP training centers was a strategy built between the programs to create spaces for reflection shared in the teaching and learning process between the programs. The link is the purpose of training a professional "health promoter" with the necessary skills and abilities to conduct HP strategies with an impact on different scenarios of practical action and promote the dissemination and exchange of scientific productions in the field.

The consortium is understood as an instrument of articulation between systems and an efficient means to achieve priority goals. From a legal and etymological viewpoint, a consortium means the union or association of two or more entities of the same nature. The consortium is not an end in itself but is itself an instrument, a means, and a way to solve problems or achieve common goals (Brasil and Ministério da Saúde, 1997; Neves & Ribeiro, 2006).

Regarding competencies for work in health promotion, based on the document Competencies for Health Promotion (CompHP) (Barry et al., 2011), the concern lies in enabling the discussion of knowledge, skills, attitudes, and essential values to support more effective practice in health promotion. Students should build the following scientific or professional skills: activate/produce changes, health advocacy, build partnerships, communication, leadership, diagnosis (needs assessment), planning, implementation, evaluation, and research. Competencies are an essential basis in health promotion training. In designing to define competencies for "health promoters," CompHP proposes a theoretical and practical model for professional training (Pinheiro et al., 2015).

Initially, the similarities between the teaching strategies of the six programs are presented to share paths, explaining the common points and the challenges that aggregate all the courses. Later, some actions carried out in common were presented to converge learning, which allows building dialogues between teaching and learning practices, generating the consortium proposal.

The curricular structures of the courses are broad, comprehensive, and flexible, with subjects addressing several HP aspects. Curriculum structures consist of mandatory and optional subjects, which seek to align the more specific theoretical needs

of graduate students with their lines of research. The programs offer curricular components that trigger different areas of knowledge that articulate with the large area of health, such as public policies, interdisciplinarity, and scientific methodology, among others that seek to overcome the logic of organizing compartmentalized, decontextualized knowledge.

All of them enable students to visualize their social nature and the particularities of their training. Classroom activities include interdisciplinary practice, and research activities are constructed, experienced, discussed, and justified by the need to fully develop students' education for the societal demands and their population segment that may receive their intervention.

All programs carry out cooperation exchanges with other universities across the world, in order to expand the consolidation of scientific and technological research in the programs. As for the national and international exchange experiences of professors and/or students, the programs encourage the realization of national and international exchanges carried out by their professors and students. Exchange programs have been established in international institutions, such as the Universidad Politécnica de Madrid, University of Michigan-MSU, University of Évora in Portugal, Universidad Autónoma de Madrid, Universities in Mexico (Universidad Tecnológica de Monterrey and Universidad Jesuita de Guadalajara), Universidad Internacional SEK, Ecuador (Uisek), Loma Linda University (United States), University of Porto (Portugal), Andrews University (United States), and Duke University (United States). At the Adventist University of Chile and at the Universidad de La República do Uruguay, professors taught subjects related to the PS framework. Participation in international research networks by professors is also highlighted.

Another common graduate programs strategy is to promote events open to the community, such as extension courses, congresses, lives, and training. Professors and students participate in interviews, round tables, programs, and print and television media comments. Also, as part of scientific dissemination, students develop informational materials for the communities in which the research is carried out. The program actions result from the establishment of partnerships and cooperation that aim to consolidate scientific and technological research in the programs based on the development of specific themes, with an integrated vision of knowledge in HP, human development, and society.

A constant concern of the courses is to align each program to the surrounding macro-regional reality to meet the needs and demands that must be considered in each territory covered. All programs absorb students from different regions (North, Northeast, Midwest, Southeast, and South).

Research projects are based on regional demands, responding to social and environmental issues where the student is inserted. Therefore, this professional returns with the necessary knowledge to perceive and change the reality in their living context. That said, HP training allows applying transformative resources to communities to reduce inequalities, create new means of dialogue, and implement protective health strategies. All stimulate teaching and research processes, which interweave different types of knowledge, show an interdisciplinary and sustainable perspective

of reality to stimulate changes in attitude and values to improve living conditions, people's health, and society's progress, as these are the necessary and expected requirements for the profile of the health-promoting professional.

All courses are staffed by professors from different academic backgrounds. They have nurses, psychologists, physiotherapists, doctors, physical education professionals, biologists, statisticians, social scientists, and educators (see Fig. 43.1). The different sets of training enable fruitful interdisciplinary exchanges. Thus, students are in touch with their initial training field and constant exchange with other types of knowledge.

Regarding the multi- and interprofessional experiences and collaborative practices in teaching, research, and extension in HP, in addition to the disciplines being shared by professionals from different areas, students take a teaching internship in the undergraduate courses, leading to an interdisciplinary understanding of health promotion for different undergraduate courses. In the same sense, the integration of undergraduate and graduate studies in research and extension activities generates motivation for the search for knowledge and solutions in health in the undergraduate and graduate academic community. Interprofessionalism in the postgraduate faculty is complemented by students from different backgrounds in health and other professional careers in different regions of the country, which adds value to the collaborative work resulting from this interaction and academic-scientific, professional, and intercultural exchanges (see Fig. 43.2). This opens up the possibility of forming graduate students with an understanding of the social and political role of their professions and with a broader knowledge of research processes.

This allows the graduate programs to contribute to HP teaching and learning through the interdisciplinary experience in the classroom, the teaching internship, research and extension projects, events, writing of papers, and an e-book with an easy language and free access to the community and integration with primary education and graduation. Thus, it prepares its students for the job market with skills to be a trained and innovative researcher investigating issues related to HP and the

Fig. 43.1 Interdisciplinary professors of graduate programs in HP in Brazil

Fig. 43.2 Interdisciplinary students of graduate programs in HP in Brazil

well-being of individuals and populations and a critical-reflective, creative, ethical researcher-educator committed to professional, interdisciplinary actions associated with HP.

In this sense, as presupposed by the HP framework, all the courses focus on interdisciplinarity, which generates diversified training, where knowledge transcends specific training boundaries and starts to be thought from an expanded and relational perspective of the various existing fields. These interdisciplinary approaches consolidate professional practices that meet a current social demand innovatively, humanely, and in a resolutive fashion.

We could perceive some common program challenges from the exchanges between the courses. One of them concerns the need to disseminate better research results and scientific publications, referring to the need to expand the number of journals that cover the interest in health promotion. Currently, the programs have some periodicals linked to the health program field, such as RECI, qualis B2; RIPS, without qualis; Pesquisa e Saúde, B4; Life Style Journal, qualis B4; and Aletheia, qualis B2.

Another challenge is the preparation of students focused on the processes of interlocution between health services to make health promotion strategies effective since they involve institutionalization aspects (economic-administrative rationality, normatization, and tensions), and even aspects related to governance, understood as a set of leadership, strategy, and control mechanisms put in place to assess, direct, and monitor management.

As it is still a challenge for universities to include health promotion in undergraduate courses' curricula (Germani et al., 2019), a constant concern of graduate programs is the training of professionals based on PNPS guidelines, taking on the expanded concept of health, considering the social determinants of health as essential in understanding the health-disease process. The proposal to reflect on moments of encounter and exchange was an almost natural consequence given the similarities between the programs, disseminated by theoretical convergence.

Converging Learning between Graduate Programs: HP Approximation and Cooperation Movements

Creating a consortium between the programs provides for an articulation between the six centers involved to carry out joint activities related to the theme, establishing a scenario of solidarity and cooperation between the courses. Indeed, not all actions are common, as each entity has specificities in teaching HP. In this section, some solidarity movements resulting from these collaborative actions between the Brazilian HP graduate programs were presented.

The first movement of cooperation between the courses was carried out in 2014 by UNICESUMAR, based on the organization of a Brazilian Interdisciplinary Congress on Health Promotion, with 507 participants, organized biannually. In 2016, UNISC was responsible for the second Brazilian Congress in the field and held 330 participants. In 2018, the third event took place at UNIFRAN, with approximately 400 participants, and UNASP hosted the fourth scientific congress on HP in 2020 and held with 415 participants. It is vital to have an exchange space to facilitate mutual contact and joint reflection and, consequently, the search for better ways to strengthen the HP in the country. With the improvement of this consortium, the last congress had 87 national and international speakers and moderators, specialists in health promotion from all over the country. With the event, there was an articulation between 25 universities, in addition to the six programs. As a strategy of dissemination and access to knowledge, the main criteria were made available free of charge and synchronous to any interest in the subject, thus the congress assumed a portion of its social responsibility. The innovation was the impetus and dissemination of the exchange of scientific productions completely online, in the context of a pandemic.

A consequent movement to strengthen these links was the publication of the book "Contemporary Health Promotion Scenarios," edited by UNASP, which included researchers and professors from the programs. The book has 12 chapters and counted on the participation of 52 researchers, which established another scenario for the exchange of scientific productions from the six postgraduate programs in health promotion in the country.

Another relevant action was constructing four editions of the "Forum of Self-Evaluation Committees of the Postgraduate Programs in Health Promotion in Brazil." Every program has its self-assessment committee. In these meetings, dialogues are built on the self-assessment processes, considering the specificities of each region and course and bringing to the debate challenges and opportunities evidenced in the processes of each program. These forums facilitate an expanded reflection on new actions in partnership and collaboration, increasing the quality and effectiveness of the proposals. The first meeting was organized in the format of a round table, and each program discussed its trajectory in the construction of the self-assessment processes, taking into account the specificities of each region and course, as well as bringing to the discussion some successes and also difficulties evidenced in the processes of self-assessment as the issue of engagement and participation of students and graduates and all the work resulting from demanding

quality metrics in graduate studies. From the positive repercussions shown by coordinators and professors after the first forum, we reflected more broadly on the joint critical-creative potential and how it could undertake new actions in partnership and collaboration. From there, we consolidated the possibility of guaranteeing the sustainability of the open debate on evaluation in the interdisciplinary graduate course in health promotion.

In this type of event, only internal professors and students interested in the theme participate. The first forum, organized by UNASP, had 59 participants; the second with 108 people was organized by UNASP; the third organized by UNICESUMAR had 100 participants; and, finally, the fourth forum had 109 subscribers and was organized by UNISC. Participation in forums creates an opportunity for integration, construction, and joint expansion of knowledge and self-assessment work strategies.

The self-assessment forums fostered interdisciplinarity, as the reflections presented by the constant evaluation of the professional training process were not taken as an end in itself but as a precious opportunity to include different actors in the process of reflection on the programs as a whole, fostering the consortium and generating information that supports decision-making, as well as for analysis and redirection of actions.

Other interlocutions are also produced in the coauthorship of scientific papers, participation in examining boards between programs, or publication of papers in the journals of the graduate programs. These partnerships thus allow academic integration in the fields of education, research, and extension. Among the main productions, awards were given for the construction of innovative strategies for the SUS, participation in books and eBooks and international scientific articles, patent application, regional and international symposia, and professional and community training courses.

Another common strategy relevant to graduate programs are the strategies of dissemination and popularization of scientific knowledge in different communication channels, such as the dissemination of news about HP actions in the media, with accessible language publications and online access and activities on organized social networks, such as forums and “lives” to gather and guide different audiences to promote well-being.

In order to offer scientific contributions in accessible language, informative materials and works with the local community were produced according to the reality of each macro-region, such as annual e-books, books, booklets, courses, videos, news on the program’ webpage, local press releases, and radio and TV programs. Still as scientific knowledge communication strategies, the programs rely on the use of social networks on Facebook, Instagram, Spotify, and YouTube, with the use of blogs, news podcasts, radio and TV programs, and mini documentaries.

The programs maintain the publication of an interdisciplinary e-book for basic education and for the SUS, with the participation of professors, students, and researchers. Scientific events with relevant promotion themes for various populations with social, educational, health, and economic impact for local and regional social and community development are also highlighted, encompassing a full commitment to students, professors, graduates, health network, and the general community.

Besides the exposed actions, based on the assumption that the best way to evaluate a postgraduate course is to know the performance of former students and how much they influence the social context, all graduate programs monitor the graduates to identify health promotion actions carried out by alumni with the community.

As for the positions they hold, most graduates are professors hired by higher education institutes from different Brazilian states. Most occupy prominent positions in the management of public policies, such as health managers at the different municipal, state, and federal management levels. Some other graduates are included in several other spaces such as industry, primary education, and the third sector, just as graduates continue their education in doctoral and postdoctoral programs from graduate courses or other institutions.

Based on the foregoing, the PPGPS counts on alumni profile surveys, as a follow-up strategy that makes it possible to know the social impacts of the training path of former students. The data show that, despite the greater concentration of graduates concentrated in the south and southeast regions of the country, where the programs are located, it was seen that there are graduates from São Paulo, Rio de Janeiro, Minas Gerais, Maranhão, Paraná, Santa Catarina, Rio Grande do Sul, Tocantins, Mato Grosso, Bahia, and Amazonas. This shows how the PPGPS contribute to the dissemination and decentralization of knowledge, pulverizing access to training.

Counting the graduates trained by the PPGPS in the country, 746 masters and 54 doctors were trained in health promotion in the country, with the most diverse academic backgrounds.

Besides professional incorporation, the transformation of the local reality also occurs through direct and indirect impacts of the inclusion of graduates, through reports, publications (papers/abstracts/chapters), proposals of events, and joint projects with the faculty members of the program and by the formal or informal evaluation by graduates' managers.

Such processes reflect the expected strengthening of the HP framework in different Brazilian contexts, as the graduates become HP multipliers, training human resources in education and public management. Thus, they improve professional training and provide health services as a whole.

A concern of the programs is related to the constant need to think about new directions for the education processes, with significant learning, with unprecedented ways of training professors and students, which connect students' previous knowledge with new scientific knowledge, especially in digital contexts.

In this sense, the programs add efforts to overcome the challenges related to the establishment of significant learning in the area, that is, learning characterized by the interaction between the professional's previous and new knowledge, nonliterally and non-arbitrarily, providing the new knowledge with meanings to people, awakening them to a proactive position before the general and scientific society concerning the actions and dissemination of HP-related productions.

Thus, the creation of the consortium joins efforts between the HEIs' programs involved in proposing actions that seek to prepare the student considering the above challenges with the application of meaningful learning active methods, escalation of

joint scientific production, and activities that consider reflections on health's specific field of tensions, understanding that the articulations are necessary strategies to respond to complex problems that impact society effectively.

Graduate programs' primary motivation is quality in the training of human resources and knowledge production, for which there is a significant investment in the implementation of programs in the strategic planning of courses. This matter has a dual challenge: preserving quality and deepening advances in the methodological path of multidimensional assessment, as recommended by the federal agency for the accreditation of postgraduate courses in the country, CAPES.

Training "Health Promoters"

Given the need to expand discussions on the social determinants of health in the face of the health-disease process, universities have strengthened academic training focusing on health promotion. A cooperation movement between six Brazilian higher education institutions that offer health promotion programs, the consortium was considered a teaching experience contributing to the advancement of the HP theory and research in Brazil.

This partnership aimed to strengthen its purposes. Coherently, the programs seek to train professionals to act innovatively and as knowledge multipliers, promoting the improvement of people's quality of life to reduce inequalities and social and regional asymmetries, reinforcing equity and solidarity principles that reaffirm democracy in social and political relationships.

As a result of the consortium, four editions of the Brazilian Interdisciplinary Congress on Health Promotion were created *change for The consortium held four editions of the "Brazilian Interdisciplinary Congress on Health Promotion,"* scientific papers, participation and collaboration in dissertation and thesis defense qualification boards, and other academic exchanges that culminated in the training of professionals with competencies and abilities for HP-based work.

The whole construct presented here allows us to affirm that the main link of the programs is in the expected common result, that is, training masters and doctors in health promotion and turning them into "health-promoting" subjects, as proposed (Pinheiro et al., 2015), where their skills and competencies are decisive for the design and implementation of strategies to improve the quality of life of the population, especially when articulated with the state (healthy public policies), community (reinforcement of community action), individuals (development of personal skills), health system (reorientation of strategies), and intersectoral partnerships.

For this training of "health-promoting" subjects, this consortium understands and advocates that the formation of professors and researchers in health should imply acquiring knowledge and technical, dynamic, dialogical, reflective, and,

mainly, ethical learning. In this sense, the experience presented here highlights the importance of reaffirming the HP principles in the training of qualified human resources, with a critical attitude toward the complex nature, making them agents of change in society.

This experience showed that the construction of networks between universities in health promotion generates opportunities for exchanging experiences and innovative ideas. These partnerships contribute to professors, students, and alumni qualification and further consolidating postgraduate programs in health promotion in the country.

The creation of this consortium among the postgraduate programs establishes the possibility of their growth and development to improve and disseminate comprehensive knowledge, meeting the different demands of society, thus strengthening the Brazilian health promotion framework.

This chapter is a reflection of an initiative to promote the dissemination and exchange of scientific productions in the field of PS. The actions developed by this consortium show that there are many challenges for the effective implementation of health promotion, from professional training to current sociocultural demands. With the purpose of joining efforts, several strategies were created, listed throughout the text, to discuss some themes that could contribute to facing such challenges.

In total, 805 health promoters were distributed across states of the country. With an interdisciplinary character, these programs involved professors, students, and graduates from various disciplines. It also showed how these programs can influence various scenarios, from the training of undergraduate students to the management of the public health system, contributing to the identification of vulnerabilities and the reduction of inequities.

The importance of collective construction in multiple interventions shows the maturity and interest of these programs in daily improvement. If, on the one hand, all programs are constantly asked to present their results, then, on the other hand, exposing their actions and/or revealing their weaknesses requires maturity. In this sense, what unified this group, even with all its diversity, was realizing that there are common challenges and having spaces for sharing experiences, generated collaborative scenarios and allowed everyone to grow together. By breaking with the search for solutions in a solitary way, this consortium proposed to overcome its barriers and share its successes and uncertainties, building a scenario of solidarity in favor of strengthening the PS. Of course, many other path possibilities can be built. However, in the final set of this text, we hope that these reflections can contribute to the construction of innovative and solidary actions and reflections.

Table 43.1 brings our reflection on the six triggering questions suggested by the editors.

Table 43.1 Authors' reflections on the six triggering questions suggested by the Editors

Questions	Take-home messages
What is our vision about HP?	Based on Ottawa charter: (1) building healthy public policies, (2) creating health-inducive environments, (3) developing personal skills, (4) strengthening community action, and (5) reorienting health services
What is the institutional and political context of your experience (participants, professions, and courses involved, duration, and frequency of activities)?	Universalization of the health system and the implementation of public policies in defense of life, incorporating the expanded concept of health as a factor resulting from ways of life, organization, and production in a given historical, social, and cultural context
Which theories and methodologies are used in the teaching-learning process?	Classroom activities includes: Interdisciplinary practice, and research activities are constructed, experienced, discussed, and justified by the need to fully develop students' education for the societal demands and their population segment that may receive their intervention
What forms of assessment are applied, results achieved, and challenges faced?	Events open to the community, such as extension courses, congresses, lives, and training. Professors and students participate in interviews, round tables, programs, and print and television media comments. Also, as part of scientific dissemination, students develop informational materials for the communities in which the research is carried out
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	Activate/produce changes, health advocacy, build partnerships, communication, leadership, diagnosis (needs assessment), planning, implementation, evaluation, and research. Competencies are an essential basis in health promotion training
What others could learn with your experience? What is localized and what is "generalizable"?	Research projects are based on regional demands, responding to social and environmental issues where the student is inserted Brazilian interdisciplinary congress on health promotion, organized biannually Forum of self-evaluation committees of the postgraduate programs in health promotion in Brazil

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Part VII
Students' Reflections

Chapter 44
Introduction to Part VII: Students' Reflections

Marco Akerman and Shu-Ti Chiou

Contents

The Voice of Students

This book, which is about "teaching and learning in health promotion," would fail miserably if lecturers' views prevailed and there was no space for learners to express their impressions and present their experiences in this process. This section addresses and captures the experiences of students during their learning process in health promotion.

The voices of lecturer's echo in classrooms (or on computer screens) around the world and they are fundamental to the teaching-learning process, and these voices have a clear receptor – the students. It is in the meanders of this conversation that the challenges and mysteries of the production of teaching and learning in any school subject are recognized.

A search on this topic on the National Library of Medicine (PUBMED, https://pubmed.ncbi.nlm.nih.gov/) using the words "students," "learning," and "perceptions," limited to article titles, retrieved 342 items that approach how students perceive their school learning process (retrieved on October 22, 2021, from https://pubmed.ncbi.nlm.nih.gov/?term=%28%28students%5BTitle%5D%29+AND+%2

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8learning%5BTitle%5D%29%29+AND+%28perceptions%5BTitle%5D%29&size=200).

Figure 44.1 shows the annual concentration of publications between 1984 and 2021; in 2011 the number of publications on this topic started to increase, and it peaks in 2019.

The analysis of the most recent articles, published in 2020 and 2021 ($N = 67$), shows a significant number of studies designed to capture the satisfaction and perception of students regarding remote/distance learning in the context of the COVID-19 pandemic. The results and conclusions of these studies present the possibility of blended learning (face-to-face + digital), probably already indicating the challenges posed by the "new normal" to the teaching-learning process in schools that will take advantage of a significant increase in open education technologies.

The topic of how students perceive their school learning process seems to interest everyone who teaches at universities, since there are studies published by authors from the five continents of the world. These studies focus mainly on the perception of students regarding the use of active methodologies – such as "cooperative learning," "team-based learning," "problem-based learning," "case-based learning," "game-based learning," "affective learning," "interpersonal learning," "critical thinking," "tutorials," and "small-group techniques" – as previous research works have already pointed out the low level of retention and student satisfaction in traditional teaching, which is solely expository.

These studies also address students' perception of teaching-learning scenarios. If the classroom becomes limited for the development of skills and behaviors, they

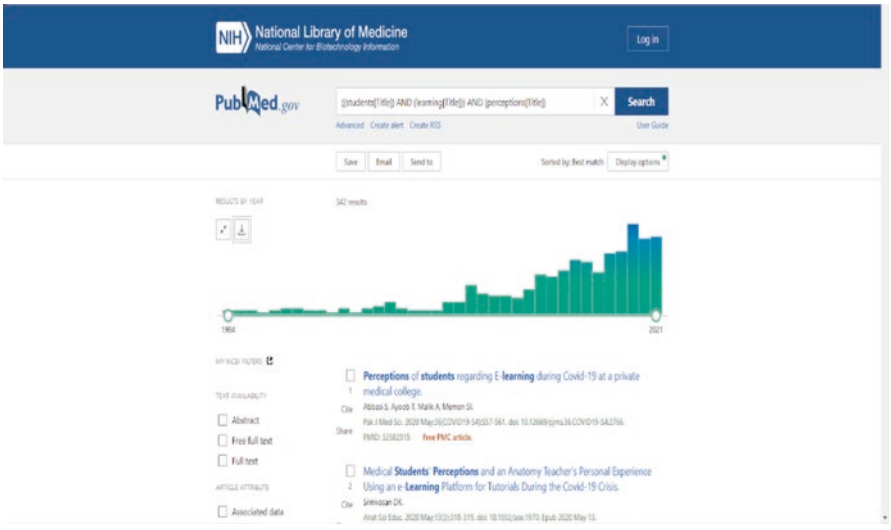

Fig. 44.1 Search results for articles on how students perceive their school learning process, per year, between 1984 and 2021, National Library of Medicine, 2021

seek to figure out how students assess their learning in "community services," "interprofessional care," "video consultations," etc.

There is also an interest in analyzing the perception of students regarding the assessment of their performance and the use of multiple evaluative devices such as "quick response codes," "OSCE," "simulation techniques," and the like to assess the effectiveness of teaching regarding "communication skills," "clinical skills". They also seek to understand the impact on student learning caused by "inclusive learning," the use of "mentoring," and the role of sports in reducing stress and increasing student motivation, self-confidence, and self-esteem in learning.

Between 1984 and 2021, we found only one study that analyzes student perception of the teaching-learning process in health promotion. This article, entitled "Students' perceptions and experiences in a health promotion course using interactive learning" and written by Ahlam Al-Natour et al. (2021), authors from the Jordan University of Science and Technology, brings the following abstract:

> There is a lack of studies that describe the experience of studying a health promotion course using an interactive approach and students' perceptions about this method of teaching. The purpose of this study is to describe students' experiences and perceptions about health promotion courses using an interactive learning approach. A descriptive qualitative design was used among 16 undergraduate university students at a governmental university. Four main themes emerged from the data analysis including: (1) fruitfulness and satisfying experience of interactive learning, (2) interactive learning versus traditional learning, (3) barriers to interactive learning, and (4) suggestions to enhance interactive learning. Students reflected positive attitudes toward interactive learning. Interactive learning helped students to be engaged in the learning process physically and cognitively. Students mentioned several advantages of learning health promotion courses using interactive learning, including, enhancing understanding, sharing ideas and opinions, promoting self-esteem and self-confidence, keeping their minds active and attentive, and improving interpersonal communication. Updated and contemporary learning strategies and methods should be introduced for enhancing interactive learning courses.

The advantages of interactive teaching mentioned by students, such as "enhancing understanding, sharing ideas and opinions, promoting self-esteem and self-confidence, keeping their minds active and attentive, and improving interpersonal communication," are, definitely, skills required for health promotion and for any other health-care practice.

We appreciate this article, but it is worth noting that there is a lack of studies that capture specifically the perception of students with regard to learning health promotion, which is why there is a special section in this book dedicated to this topic.

So, let us "listen" to what the students who submitted their chapters for this book "have to say" to us.

Special Voices from Health Promotion Students

This section comprises two chapters, as follows: Chap. 45, A Student Perspective on Learning and Doing Settings-Based Health Promotion in the Era of TikTok by Catherine Jenkins, from London South Bank University, London, UK; and Chap. 46, The Impact that Learning About Health Promotion Had on Me. Embracing Health Promotion: A Puerto Rican Metamorphosis by Elisa Ramos-Vázquez and colleagues.

Chapter 45 reflects the present time as it was written during the COVID-19 pandemic and, as shown by several studies mentioned above, it used digital devices to develop its teaching-learning process. However, there has been a need to adjust its existing digital literacy to something more complex, i.e., digital health literacy.

According to Jenkins, both what she has been learning at the university and the context of life concretely produced by social relations have an impact on her. Thus, the COVID-19 pandemic was emblematic in this sense: "Witnessing the impacts of this twenty-first-century determinant of health in real-time, as the pandemic played out, has been instrumental in my learning and development as a student and early-career practitioner of health promotion and to my awareness of the work required if #HealthForAll – rather than just #ForYou, the TikTok users' homepage tag (TikTok Cultures Research 2020) – is to be realized 'IRL' (in real life)."

She also highlights the growing demand from students for more active methodologies for interactive learning: "It is necessary to promote health promotion to students as a career that practices what it preaches in terms of transparency and its translation of learning into informed action…talks by health promotion professionals from a variety of backgrounds and at different stages of their health promotion career life-course provides a model for transforming health promotion to #HealthPromotion," emphasizing what has already been shown by research regarding the need for a hybrid teaching and learning process and health promotion practice: "a community-generated tag for a shared endeavor that is well-prepared for what marketing calls a 'phygital' future of physical and digital engagement with health."

The other Chap. 46, has in its title an intriguing word – "metamorphosis," which means transformation, change, transition, and movement. Please read this chapter with joy because the most important in a teaching-learning process is that it makes sense for learners and that they are able to produce changes and reflections in their professional doing and acting. This chapter brings many examples to illustrate student views, and the voices of students who are the authors of this chapter state that "When we go through a metamorphosis, we are transforming ourselves from one form to another; We are modifying the structure beyond what is thought or imagined, and we are changing the state in which we found ourselves through our action in the face of the conditions necessary for these changes."

For them, metamorphosis is a sine qua non for learning health promotion, as "developing a vision for health promotion requires breaking mindsets."

Enjoy your reading of these two chapters and make them an inspiration to always include students not as passive subjects in the teaching-learning process in health promotion but as fundamental partners in the construction of meaningful and transformative learning.

Then, dialogue with students bearing in mind this quote by Lima (2015), based on the teachings of Paulo Freire (a Brazilian educator, 1921–1997):

> Pedagogical work is communitarian, and subjects are communitarian. The subject of education is not the educator, and students are not their objects. The subject of education is not the student, and knowledge is not their object. Historical subjects, while oppressed, participating in life, and immersed in life, who free themselves in a process of awareness based on their daily lives and culture, are subjects in relation to other subjects and while working in the construction of the world. Education is a dialogue between subjects; it is dialogical. The subjects in a given situation. Therefore, it is the duty of educators to dive into students' daily lives, culture, and knowledge. They need to dialogue, engage, and recognize themselves as subjects. Dialogue is not about throwing your ideas at others.

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Chapter 45
A Student Perspective on Learning and Doing Settings-Based Health Promotion in the Era of TikTok

Catherine L. Jenkins

Contents

Setting the Scene: Twenty-First Century Health Promotion in the UK

On 28 February 2020, under the hashtag #HealthForAll, the World Health Organization (WHO) launched its verified account on the video-sharing app TikTok to combat COVID-19 misinformation. COVID-19 exacerbated the existing digital divide in the UK (Good Things Foundation, 2020). Witnessing the impacts of this twenty-first-century determinant of health in real time, as the pandemic played out, has been instrumental to my learning and development as a student and early-career practitioner of health promotion and to my awareness of the work required if #HealthForAll – rather than just #ForYou, the TikTok users' homepage tag (TikTok Cultures Research, 2020) – is to be realised 'IRL' (in real life).

My approach to the study of health promotion is shaped by a background in information science and 2 years' work experience as Health Literacy Project Manager within a National Health Service (NHS) library. Health literacy is defined

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by the WHO as the social resources that enable individuals and communities to access, understand and use information to make informed decisions about health (Nutbeam, 1998). More than being able to read and understand a patient information leaflet, health literacy is an asset which can support people to improve the self-management of their health and navigate the settings of everyday life (including online settings). It is a distinct but compatible piece in the wider puzzle of health promotion (Nutbeam et al., 2018). Without health literacy, health promotion and #HealthForAll 'cannot be meaningfully achieved' (Nash et al., 2018, p. 1).

Low health literacy increases health inequities, leads to poorer health outcomes and costs the NHS time and money (Berry, 2016). It is a significant problem in England: 61% of adults aged 16–65 years struggle to understand health information when numbers are involved (Rowlands et al., 2015). The Health Literacy Project Manager role was created in November 2018 with the purpose of reducing the gap between health-related information complexity and the health literacy levels of the populations served by the NHS trust where I work. This remit includes the London borough of Waltham Forest where, at 76%, the prevalence of low health literacy exceeds the England average (GeoData Institute, 2016).

The Health Literacy Project Manager role is aligned with and contributes to national efforts by Health Education England (HEE) and the Royal Society for Public Health (RSPH) to improve individual and systemic health literacy holistically (NHS England, n.d.). Social prescribing is one way to develop health literacy and help people to take control of their health (National Academy for Social Prescribing, 2019), and I work closely with local public health teams to signpost to accessible, high-quality health information via social prescribing in partnership with public libraries, some of which are co-located with healthcare settings. I am currently drawing upon this experience to inform doctoral research into health literacy-promoting settings.

The health promotion work I undertake with public libraries takes a proportionate universalism approach to addressing the inverse information law (Rowlands & Nutbeam, 2013) – whereby those members of society most in need of information are also those least able to access such information – at each stage of the life course. Activities range from early literacy programmes and death cafés to Making Every Contact Count (MECC) conversations and reminiscence sessions for people living with dementia.

UK public libraries are supported in these activities by the Universal Health Offer (Libraries Connected, 2018), which sets out how public libraries can develop their users' health literacy and self-management through the provision of health information and the hosting of health promotion events. As part of this, evidence-based collections of books for mental and physical health curated by The Reading Agency under the 'Reading Well: Books on Prescription' scheme are available to borrow from UK public libraries for free in print (with selected titles also available in audio and e-book formats) via two pathways: self-directed social prescribing or through general practitioner (GP) referral. As of April 2021, there are five book collections available:

- Reading Well for children (updated post-March 2020 to include corona-specific resources).
- Reading Well for young people (marketed as Shelf Help).
- Reading Well for mental health.
- Reading Well for long-term conditions.
- Reading Well for dementia (including reminiscence resources and children's books that people living with dementia or their carers can read with younger relatives/friends).

The titles in the child- and adolescent-specific collections are regularly reviewed by a panel of child and adolescent health professionals, including GPs, psychiatrists, child and adolescent mental health (CAMHS) workers, public and school librarians and young experts by experience. I contributed to the selection process for the Reading Well for children booklist, launched in February 2020. Many UK public library buildings physically closed shortly after the launch to mitigate the spread of COVID-19. The loss of the free WiFi provided by public libraries impacted outreach to digitally excluded communities and necessitated a pivot in my learning and practice towards the literacies needed for pandemic-era health promotion: digital literacy, misinformation and disinformation literacy and social media literacy.

The Preliterate Phase: An Interdisciplinary Journey Towards Professional Literacy in the Language of Health Promotion

My health promotion journey has followed an interdisciplinary trajectory: prior to developing professional literacy in the language of health promotion, I worked on an open access research publishing programme involving Wellcome Trust-funded medical humanities outputs. When I joined the NHS, I transferred my understanding of research management and dissemination to the health literacy role and from the outset viewed my partnership projects with public libraries – whether conducted in person (floor-walking and drop-in 'information prescription' sessions) or online through takeovers of public library social media accounts – as providing frontline public health services to meet the needs of underserved populations. Public libraries' accessibility and reach make them 'unique settings' (Whitelaw et al., 2017, p. 897) accessible to all, including non-members of the library, for health-related learning, work and play (WHO, 1986).

The focus on promoting health literacy on the ground through public libraries nurtured my interest in the academic research underpinning my career development. The result of being research-curious was twofold: I began a PhD focusing on settings-based health literacy and joined the 2021 cohort preparing for UK Public Health Register (UKPHR) validation as an early-career health promotion practitioner. Both experiences have provided opportunities to reflect on how newcomers to health promotion are introduced to it through the canon of published studies most likely to appear on reading lists in introductory textbooks: the key texts and models which carry conceptual currency in the field, referred to in shorthand by those in the

know (‘the Marmot Review’, ‘the Dahlgren-Whitehead rainbow’). The scholarly record influences the emphases that aspiring health promotion professionals are taught to place on aspects of their work and the process by which certain aspects come to be recognised by health promotion’s academic influencers as properly pertaining to health promotion, or as researchable within it. Where TikTok deploys creator notifications (to inform creators when they produce videos featuring effects that could e.g. trigger photosensitive epilepsy), health promotion deploys creator constrictions: my attempts to slot health literacy into the larger health promotion jigsaw are circumscribed by prevailing prescriptions of what is, and is not, defined as health promotion within the disciplinary discourse.

COVID-19 injected new language into this discourse (Sørensen et al., 2021). Pre-pandemic, I had rated my personal ‘health promotion literacy’ based on how well I understood and could demonstrate application of the UKPHR standards (Health Education England, 2021) for professional registration. The aspiration to become ‘literate’ in health promotion led me to consider what this type of literacy might enable me to do, like identifying health-related fake news and sharing this skillset with others. As someone with neither ‘health promotion’ nor ‘public health’ in their job title, I had previously despaired over preparing the evidence required for my professional portfolio; recasting my experiences through a literacy lens helped me to see how I might match my knowledge to individual UKPHR standards in new ways.

My concerns that I was ‘a bad health promoter’ – even an imposter health promoter – led to strategies to develop myself as a literate learner of health promotion by putting into practice Luke and Freebody's (1999) ‘four resources’ model and adapting it to my purposes of codebreaking, making meaning from, participating in and analysing health promotion’s texts and tenets. Applying this model taught me to critically ‘read’ health promotion as an institution, just as *How to Read a Paper: The Basics of Evidence-Based Medicine* (Greenhalgh, 2014) taught me how to critically appraise research and David Spiegelhalter’s Tweetorials on risk taught me how to interpret data on vaccination safety (@d_spiegel, 2021). Developing critical health promotion literacy has brought me a step closer to fluency in the field. But there remains a need for health promotion itself to become more health literate and digitally literate and more conducive to being understood as important for population health today by the audiences it seeks to serve.

Theory into Practice: Adapting to Online Settings

Settings ‘represent the organizational base of the infrastructure required for health promotion’ (WHO, 1997, p. 6). The long-standing association between health promotion and settings is reflected in health promotion’s milestone policies, which by convention are titled based on the conference locations where they were ratified (see WHO, 1991, 1997, 2016). Originally documented in the Ottawa Charter (WHO, 1986), settings-based health promotion or ‘the settings approach’ underpins my work and research. Instead of relegating settings to the background – as in, ‘health promotion in settings’ (Dooris 2006, p. 59) – the settings approach promotes

settings to the starring role of interventions, focusing on how settings can actively create and contribute to health rather than 'simply ensure we don't experience poor health within them' (Hodgins, 2008, p. 17). Ilona Kickbusch pairs a settings approach 'done right' with action on the social determinants of health:

> If a settings approach is done properly, then it does address the determinants of health – it changes people's working environments, it changes the way work is organised, it empowers them as patients or as school children […] The big issues always reflect themselves in people's everyday lives and unless you provide a political space for empowerment – which is essentially what the settings do – you're not really doing health promotion.– (Kickbusch, interviewed in Dooris, 2013, p. 45)

Today, the settings approach has not kept pace with the new social determinants of health arising from the pandemic and the consequent hybridisation of settings beyond the official list of WHO-endorsed healthy settings (WHO, n.d.). The absence of online settings from the WHO list has also impeded progress in settings-based interventions to develop health literacy, which historically have not strayed far from the same settings (cities, communities and neighbourhoods, education, healthcare, prisons, workplaces). An updated settings approach for pandemic-era health promotion is urgently needed (IUHPE Global Working Group on Healthy Settings, 2021).

Newman et al.'s (2015) rapid review of settings for raising awareness of health inequities provides a blueprint for such an update: while building on the WHO's list, the review provides evidence for the health-promoting potential of additional settings, including online, faith-based, sports, nightlife, green and temporary or pop-up ones. Even before the first UK wave of COVID-19 in early 2020 routinised online homeschooling for children of non-essential workers, Newman et al. (2015) ranked online settings second in terms of frequency in the literature reviewed (below physically accessed education settings and above healthcare settings).

Approaching the settings approach from alternative angles, as Newman et al. (2015) do via opening hours, ecological footprint and permanence, is important for ensuring the roster of settings for health promotion and health literacy development remains relevant. Combining Newman et al.'s (2015) findings with wider reading (Whitelaw et al., 2017) highlighted for me the potential of public libraries to be included as new entrants to the WHO list. In the UK, public library settings continued to offer in-person support alongside online services throughout lockdown (e.g. providing 3D-printing facilities for manufacturing personal protective equipment (PPE), distributing food parcels for children during school closures and reaching out to digitally excluded local residents through well-being telephone calls). The shift to online settings in my work with public libraries entailed retooling and retraining, from learning how to use Zoom to how to create memes and gifs championing health promotion (@VaccineSafetyNet, 2021). My education also moved online: I continued compiling my evidence portfolio for UKPHR remotely and attended live and asynchronous health promotion lectures from home, using backchannels like Zoom's chat function and WhatsApp to make connections with other practitioners and students in the absence of opportunities for in-person networking.

Social distancing became so normalised in my life that watching television series and films made or set prior to 2020 and which featured large crowd scenes and up-close interpersonal contact became surreally stressful. This was especially the case with the

television series *It's a Sin* (Channel 4, 2021), about the onset of AIDS in the UK. A scene where one character requests another to bring back any pamphlets or zines they can find relating to AIDS from a trip to New York, because of a lack of information available in the local public library, resonated with my memories of the early days of COVID-19 (when it was a news story reported from outside my filter bubble and epidemiological terms had not yet become hashtags). Frerichs's (2016) epidemiology primer and exposé of a misinformation campaign around the source of a cholera outbreak also made for a discomfiting re-reading experience in my new context.

The interruption by COVID-19 of established ways of doing health promotion and research afforded me space to rethink learning models and epistemological and ontological commitments I had previously lived by. This reset extended to how best to translate the settings-based research I had planned back in 2019 to an online and remote context. The result approached a form of meta-research, as health promotion online became both the means of access to learning and the learning goal itself.

Information Overload: Balancing Informed Practice with the Infodemic

The term 'infodemic' predates the coronavirus pandemic: it was coined to describe the proliferation of unsubstantiated information intensifying public anxiety during the SARS epidemic of 2003 (OED Online, 2021). With the shift of health promotion teaching to online settings, I was inundated with learning opportunities related to tackling the infodemic: London South Bank University (LSBU) ran a series of public health masterclasses, the International Union for Health Promotion and Education (IUHPE) convened webinars, the WHO initiated a regular infodemic management news flash briefing containing a plethora of links to yet more webinars, and my health-related podcast queue began to look as intimidating as the 'to-read' list in my reference management software. Sifting through the available educational sessions on offer took time away from my health literacy role and research as I attempted to balance the consumption of new information with the consolidation of what I already knew, or needed to revisit: should I attend a webinar on the sophisticated scams designed to look like NHS vaccination invitations? Should I listen to an episode of Public Health Disrupted (UCL Health of the Public, 2021) on how stand-up comedy could be integrated into health promotion? How could I manage – and, when hosting training myself, *compete with* – this information overload?

I am a regular user of social media for continuing professional development (CPD) and horizon scanning of trends and topics in health promotion and health literacy. Part of this usage includes practising social media literacy to ensure that I am in charge of my social media consumption – and not the other way round! – through initiatives like #PledgetoPause (taking time to reflect and fact-check before sharing information). The potential of health promotion for harnessing and taking control of the infodemic as a dataset from which to gather insights is demonstrated by Southerton's (2020) analysis of TikTok as a health promotion tool: TikTok's popular trend of lip-syncing can indeed save lives, Southerton argues, if health

promotion professionals are the ones creating the trending videos.Approaching health promotion obliquely, or with a disruptive mindset – not stand-up comedy in my case but leveraging social media and maintaining a presence on the platforms where the audiences I would like to reach spend time – proved useful for helping me to overcome the ethical and practical challenges of doing research in a pandemic and including children and young people in ways that recognised their rights and met patient and public involvement and engagement (PPIE) best practices. In the same way that the 'Ethical and Legal Values in Public Health' lecture in LSBU's series of public health masterclasses I attended was able to incorporate live reactions to vaccine hesitancy debates unfolding synchronously offline, I was able to discuss with young research participants over Zoom the topics that mattered most to them right now and to which they could make a difference by their own actions (e.g. mask wearing). Provision of refurbished digital devices with preloaded data to digitally excluded households was essential for training children as digital health champions who could then cascade their learning to older family members and friends (IHLA, 2021). With the help of youth-created memes like @VaccineSafetyNet's curated GIPHY collection, shareable animated explainers (The Spinoff, 2021), fact-checker social media accounts like Twitter's @viralfacts and influencers like (medically trained) Dr. Ranj (@drranj), perhaps health promotion can do what an April 2021 TikTok on the need for two doses of a coronavirus vaccine (@hotvickkrishna, 2021) did: cut through the noise and go #viral.

Looking Forward: Health Promo(tion) Online and IRL

COVID-19 led to the disappearance of a once-common student job, conducted across offline and online settings: nightclub promoter. How can health promotion become as ubiquitous in our social media feeds and on our streets as nightclub promoters once were (and, when nightlife returns post-pandemic, may be again)? Discussions at a webinar to mark 70 years since the foundation of IUHPE (IUHPE, 2021) provided food for thought on what the next 70 years of health promotion should look like and what needs to happen to ensure that health promotion practice itself is health promoting. As an example of the disconnect between the #HealthForAll goal and health promotion in reality, the preset fields of my university's ethics application form did not list any ethics guideline specific to health promotion as an option, with the result that I ended up selecting the Social Research Association: Ethical Guidelines. The lack of a unified ethical framework for health promotion that is sufficiently recognised to be included on university ethics forms is an essential component towards the realisation of a health promotion practice that is authentically aligned (#nofilter) with health promotion values. It might be expected that the teaching and learning of health promotion during a public health emergency would automatically be conferred with importance and taken seriously. But health promotion's fragmented representation as a discipline and profession in its own right (IUHPE, 2021) has meant that, too often in the present pandemic, the voice of health promotion has been effectively drowned out by algorithms that

reward conspiracy theories over reliable health information (even after partnerships between social media companies and health organisations, like the one between TikTok and WHO). Rewriting these algorithms to establish social media as a health-promoting setting, buttressed by robust strategies for digital inclusion, offers an opportunity to advance the health promotion agenda.

To attain the solidarity, equity and transformation in health called for by IUHPE (2021), it is necessary to promote health promotion to students as a career that practises what it preaches in terms of transparency and the translation of learning into informed action (Guo et al., 2020). LSBU's 2020–2021 lunchtime talks by health promotion professionals from a variety of backgrounds and at different stages of their health promotion career life course provided a model for transforming health promotion to #HealthPromotion – a community-generated hashtag for a shared endeavour that is well prepared for what marketing calls a 'phygital' future of physical and digital engagement with health.

Table 45.1 contains my reflection on the six trigger questions suggested by the editors.

Table 45.1 Author's reflections on the six trigger questions suggested by the editors

Questions	Take-home messages
What is your vision about HP?	Health promotion should promote the health interests of individuals and communities. In combination with (increasingly digital) health literacy, health promotion should support people to determine the health determinants relevant to them and advocate for the co-creation of #HealthForAll in all policies and places
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	My experience as a student of health promotion spans professions (librarianship, public health), disciplines (health literacy, information science, open science) and participants (public library and medical library, staff, school staff, children and young people, expert patients, people living with dementia and their carers, homeless service users, Recovery College graduates). I have been embedded in a library and knowledge services team within the National Health Service (NHS) as Health Literacy Project Manager from November 2018 to the time of writing (April 2021). I started a 3-year PhD in children's health literacy, informed by health promotion research and practice, in October 2019. I am currently participating in the 2021 cohort working towards professional registration with the UK Public Health Register (UKPHR) as an early-career health promotion practitioner
Which theories and methodologies are used in the teaching-learning process?	The theories and methodologies that I have been exposed to through lectures, and which continue to frame my thinking in relation to health promotion, include the social determinants of health, the proportionate universalism approach and the settings approach. As part of my PhD, I am applying institutional ethnography as a mode of inquiry for studying healthy settings

(continued)

Table 45.1 (continued)

Questions	Take-home messages
What forms of assessment are applied, results achieved and challenges faced?	Health promotion lectures and masterclasses delivered over Zoom incorporate regular checks for understanding via interactive and participatory elements, including submitting comments and answers to questions in the chat box, voting in online polls and small-group discussion using the breakout rooms function. Continuing professional development (CPD) is challenging in a time of social distancing and reduced face-to-face support: the UKPHR validation scheme is being delivered remotely, and it is difficult to replicate online the serendipity of in-person networking that the pre-pandemic version of the scheme was able to facilitate
Which principles, pillars, competencies or approaches to health promotion do you base your plan of teaching and learning on?	My learning draws on several of the core competencies for health promotion, as outlined by the CompHP framework: a multidisciplinary knowledge base (including the significance of multiple literacies, e.g. digital literacy as well as health literacy), a commitment to enabling change and supporting self-advocacy (underpinned by critical pedagogies), partnerships with novel settings for health (e.g. public libraries) and the importance of embedding evaluation and research into practice
What could others learn from your experience? What is localised, and what is 'generalisable'?	My work on the health promotion remit of public libraries is UK-specific, but public libraries internationally are involved in health promotion work (e.g. staff at Philadelphia's McPherson Square library are trained to administer emergency naloxone to treat heroin overdoses, and Australian libraries employ library social workers). Enabling engagement with populations on social media is more generalisable: e.g. the @viralfacts Twitter account, although focused on Africa, offers lessons in best practices for a national approach to challenging health misinformation in other countries. There is much to be learned from comparing the ways in which community-based settings, operating in different physical and online contexts, are supporting digitally excluded populations to access health information and services during the pandemic

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Chapter 46
The Impact That Learning About Health Promotion Had on Me. Embracing Health Promotion: A Puerto Rican Metamorphosis

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The metamorphosis comes from *Greek meta* and *morph*, which mean beyond or structure change, and *osis*, which refers to actions, conditions, or states (Significado de Metamorfósis, 2019). Through a metamorphosis, we are transforming from one form to another; we are changing a state or structure beyond what is imagined in the face of the conditions necessary for these changes.

Our metamorphosis comes from our studies at the Medical Sciences Campus of the University of Puerto Rico. We will refer to it by its acronym MCS-UPR or as the university. The UPR is the oldest public university education system on the island.

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The UPR expansion throughout the island took decades under the control of United States and Puerto Rico's relations (López-Yustos, 1997). To contextualize our transformation as a result of our studies at MCS-UPR, a short look is needed on United States and Puerto Rico's relations and the origin of MCS-UPR.

Puerto Rico is a territory of the United States, by agreement of the Treaty of Paris of 1898 after the Spanish American War. United States Congress Public Law 81–600, of July 3, 1950, allowed Puerto Rico to organize its own constitutional government but only to control the internal government activities. There was no alteration of the unincorporated territory condition under the Congress control (U.S. Const. Art. IV, Sect. 3, cl. 2).

From the beginning, the relationship was marked by North America visions and latent stereotypes. So much that Commander General John R. Brooke decided to change the island name to "Puerto Rico," an official decision until 1932 (Vila Biaggiel, 2016). Other decisions of the military government were the Insular Normal School creation. This school was to prepare American teachers to teach in the public instruction system (López-Yustos, 1997; Maldonado-Jiménez, 2001). After 1902, the Normal School was founded in the town of Río Piedras. This was the beginning of the future Insular University, founded by law in 1903, as the University of Puerto Rico.

In the nineteenth century, Puerto Rico's major health problems were anemia, malnutrition, and parasitism. The North American government developed actions to attend to the population conditions of health and thus began the Institute of Tropical Medicine in 1912, which in 1926 became the School of Tropical Medicine (Escuela de Medicina Tropical, n.d.). Since 1972, the buildings that house the School of Medicine and other specialized schools, unique in Puerto Rico, such as Pharmacy (1913), Dentistry (1957), the Graduate School of Public Health (1970), the School of Health Professions (1976), and the School of Nursing (1995), are located on the grounds of the Medical Center (University of Puerto Rico, Medical Sciences Campus, 2021).

We are the first class starting the widely reviewed curriculum of the bachelor's degree in health education and health promotion, as approved by the university governance authorities (University of Puerto Rico, 2019). We began at MSC-UPR in August 2020, precisely at the same time that education is immersed in virtual environments and non-face-to-face teaching experiences, due to the COVID-19 pandemic. The virtuality of the first practical experiences was a great challenge. Despite this, we are living the process of personal and professional transformation as students of health education and health promotion. The curricular and extracurricular experiences – as necessary conditions for metamorphosis – have led us to expand our ways of seeing and understanding the world and the human being.

Health promotion does not occur in isolation and without the specialized intervention of a trained and versatile professional. We need to be endowed with learning-to-learn skills and of effective communication competencies to be part of the same vision of health promotion. Our health promotion vision has been emerging from the changes occurring in our minds, as a result of building and reconstructing knowledge during the process of learning and reflecting. Our own Puerto Rican

culture and the way we approach studies, homework, and preparation for practical courses are inherent elements of the same vision that we are shaping on health promotion. Let's see.

A Homo Universalis as an Inherent Element

As health workers, health promoters are not distinguished using a white coat nor by any uniform that makes them easily recognized. Nor do they stand out because they are entitled to a professional license regulated by the state to practice the profession, granted exclusively to the educator and health promoter over other health professionals. So, our idea about health promotion work had been limited to the creation of educational content for outreach to patients, and in sales assistance and marketing very well dominated by private companies not by public government agencies. Therefore, it was reasonable for us to think about the need to privatize public health services in Puerto Rico and eradicate all government control over them. Study about health promotion surprised us by transforming several of our own concepts and beliefs and has been one of the wisest decisions of our lives.

The first courses in health education and promotion taught us to appreciate the importance of public service in the health field. Through the courses on Health Promotion (EDSA 4020, 3 crs, 54 hours), the Educational Process in Health Promotion and Education (EDSA 4013, 4 crs, 72 hours), the Practical Experiences I – Public Health and the role of the Health Educator (EDSA 4052, 2 crs, 36 hours), and the Social Determinants of Health (EDSA 4054, 3 crs, 54 hours), we exposed ourselves to know what the past public health system in Puerto Rico was. Puerto Rico had a public health service focused on the prevention of the disease with direct service to the patient and with promotion and prevention interventions at regionalized levels, including schools and the community.

In the aforementioned courses, we also studied about what health services are in other countries of the world; and what the public management of governments represents on the social determinants of health. Yet, it is not just a matter of knowing and being willing to know but of applying, of doing to achieve changes in the health situations that many people face because of the determinants that condition them. We began to feel the enormous need to be part of the change. We convinced ourselves that this possibility of change is in the direct hands of the governments and not of private companies. The primary leader will always be the government. It is the government that has the power and resources to articulate a socially organized response aimed at promoting, maintaining, and protecting the health of the community and preventing disease, injury, and disability (Constitución de la Organización Mundial de la Salud, 1948).

Health promotion is a highly specialized management that facilitates the development of policies, procedures, interventions, and systems that lead to the holistic health of individuals, groups, communities, and society in general. A health promoter exhibits a fervent desire and determination to become saturated with vast

knowledge in priority health issues and in various other fields in connection with the health sector. The health promoter is aware of the need for access to information and decision-making conducive to health, to increase health literacy. An *homo universalis* within health systems, as we must learn to read carefully, discern information, study on our own, and learn by doing. The first of the practical experiences in the program (EDSA 4052, 36 hours) allowed us to learn about these competencies and the role of the health promoter, by conducting interviews with these professionals in their real environment. We were able to learn about the challenges they face and the limitations to access resources due to the intervention of companies with economic production interests that are opposed to health well-being. We liked this experience because we were able to get closer to that reality outside the academy and learning by doing. As students in training, we realize that these professional requirements and competencies do not change since we receive different occupational titles and/or work in a wide variety of public and private settings (hospitals, clinics, schools, universities, government, nonprofit organizations, business). It is this versatility and *homo universalis* capacity that makes a health educator an indispensable specialist in health promotion at all levels of the health services sector.

A Treasure That Shakes the Schemes

Developing a vision for health promotion required breaking mindsets. Talking about health is not referring to the simple idea of not being sick. In the beginning, our vision was shaken by the definition: "health is a state of complete physical, mental and social well-being, and not only the absence of affections or diseases" (Organización Mundial de la Salud [OMS], 2016a, 2016b). The discussion of this definition made us understand that the concept of "health" is defined from the individual and collective reality itself, considering the biosocial determinants. The analysis of the Ottawa Charter,[1] the Jakarta Declaration,[2] and the Shanghai Declaration[3] was also of impact to understand the right to health as a universal right. The maximum realization of this right depends on how social groups, professionals, and health personnel become mediators between antagonistic interests and interests in favor of health.

Advocate for physical, mental, and social well-being must consider the biosocial determinants of the multiple groups in a society, in order to discover resources, challenges, and disadvantages with which to work from health promotion strategies. It is discovering and sharing the treasure of what is its well-being that transcends the mere objective of having healthy lives, to accentuate social, personal, and physical resources as the source of wealth of everyday life. A treasure that must be possible

[1] Pan American Health Organization [PAHO] (1986)

[2] Organización Mundial de la Salud [OMS] (1997)

[3] OMS (2016a, b)

for everyone and whose main route is health promotion, according to the needs and specific literacy of the community where the intervention is carried out. Health promotion shapes, channels, and makes access to the treasure that is health for humanity and life itself. Understanding this reality entails a frank revision of the mental schemes, a personal and social metamorphosis, as well as changes in the structures of essential services systems.

With the Desire of the Caterpillar to Transform and Take Flight

Studying health promotion has led to a variety of well thought out stages in the curriculum. We are immersed in a dynamic full of initial direction that progressively changes to a dynamic of our own initiatives, so that we can expand in the construction and reconstruction of knowledge. The specialty courses taken so far require a large amount of reading and critical analysis tasks, with introspection on our beliefs, values, visions, and ideas on the holistic concept of health. However, there are several subjects that require additional study and reading time, without affecting our dedication to learning. These subjects are in the courses of Introduction to Epidemiological Methodology (EPID 4201, 3 crs, 54 hours) and Introduction to Research (EDSA 4046, 3 crs, 54 hours).

The introduction to epidemiology required us to master an elaborate scientific terminology complex to understand. With hungry determination we succeeded, and we learned to identify and understand the origins of the misinformation that is often seen in the media. On the other hand, the task of conducting exploratory research on the stigma that arises toward COVID-19-positive people allowed us to approach a real scenario and nourish ourselves on the importance of research in the field of health. For both courses we dedicate ourselves with the eagerness shown by a caterpillar to devour the leaves of a leafy tree to become a chrysalis ready for metamorphosis.

The COVID-19 pandemic allowed, to our advantage, that information flowed like a spring of fresh water on the same riverbank. On the radio, on the Internet, on television, on advertising banners, and in many other places, you could have access to emerging information and to study, evaluate, and distinguish between good and bad health promotion practices. We continually searched for information on the web pages of the Puerto Rico Department of Health. But we also began to follow the health departments of other states in North America and in other countries in the world (Spain, Saudi Arabia, France, Portugal, China, Japan, and the Philippines). We wanted to learn more and more, as part of the official courses of the curriculum, as well as through our volunteer foray into other extracurricular activities related to health promotion. Some of us are health communicators, social media managers, creators of web pages and content for networks, and collaborators in the development of materials for health promotion on various topics (Pap tests, diabetes,

hypertension, misinformation, and promotion of coexistence ideas without COVID-19). This has been together with Health Squad, a group of doctors and mental health specialists. Other extracurricular activities that have contributed to our metamorphosis process are:

1. Student Committee for the Promotion of Global Health, as part of the Research Institute for Global Health Promotion and Health Education (IIPESAG, for its acronym in Spanish). In this committee we make up the members and the board of directors. By virtue of the committee, we virtually attended the Global Health & Innovation Conference, from April 8 to 11, 2021. We confirmed the importance of collaborative action in favor of health, considering population needs. However, it is not only about health promotion knowledge, but it is also about how we can use that knowledge to empower people. For our committee promotional activities, one of our fellow students oversees producing audiovisual content for social networks. Examples of these works are:

    - https://www.facebook.com/cepsgrcm/photos/134931431988651
    - https://www.facebook.com/cepsgrcm/photos/a.107047454777049/125809612900833/

1. The tasks in this committee relate us to specific health promotion strategies such as being association cofounders, work as group leaders and mediators, and maintain effective communication with teamwork.
2. As your own initiative and as a skill practice to achieve short creative content episodes, the same fellow student is producing podcasts called Saludos en Salud. Watch https://www.youtube.com/watch?v=M7SbQLKUi5Y.
3. The same student who is producing the podcast "Saludos en Salud" offers advice on the development of social networks visual content for Civil Association for Health Promotion and the Provincial Organizing Committee of Jujuy Argentina, for the 2021 Volunteering of the Conference on Health Promotion and Education.
4. Educational interventions in VIVA System Program, which promotes safe elderly water aerobics. These experiences allow us to practice and develop confidence in communication skills.

We are eager to learn everything and to follow the guidance of trained professors, who challenge us to clash with our life and health ideas, and with the importance of being present in society and the world at present. Our professors encourage us to devour knowledge in many ways and to get out of the cocoon and fly. They challenge us to see beyond what we superficially perceive, and they support our own initiative and self-growth.

Embed from People's Shoes

In Practical Experiences I and II (EDSA 4052, 2 crs, 36 hours and EDSA 4158, 2 crs, 36 hours), we learned about individual change concepts, learning models, and health promotion theories. But, from theoretical learning to practice, there is a thematic saturation thirsty path. Health promotion requires a well-prepared specialist, both in the subject to be worked on and in the challenges that may arise in promotional work and related information. We must try to think like everyone else. Symbolically, it is putting on their shoes to achieve a better process of awareness and change.

A significant experience that proved the need to be well prepared on the issues was with church members and their vaccine myths and beliefs. We had to challenge the belief that vaccines insert a mark that would prevent God's salvation. We had to study Biblical verses cited by participants in support of that belief. In the matter of salvation, we proposed to reflect on our God saved life for all believers. We told: "You believe that God saved your life by sacrificing His most beloved son, so why wouldn't God want you to get vaccinated, so you don't end up on a respirator and lose your life to COVID-19?" Taking its religious foundations as a starting point, we captivated the audience and got group receptivity to COVID-19 vaccination.

Entrepreneurship from the Heart

An entrepreneurship experience from the heart is a project developed by one of our fellow students, in memory of her grandmother's care given. The project is aligned to five (5) Sustainable Development Goals of the United Nations[4]:

1. Objective 3 (Guarantee a healthy life and promote well-being for all): Supporting needs such as food preparation, medication reminders, light personal and household hygiene, laundry, going to medical appointments, recreational activities, etc.
2. Goal 8 (Decent work and economic growth): The project has been created over 155 decent employment working conditions, with income above the federal minimum.
3. Goal 9 (Water, industry, innovation, and infrastructure) and Goal 13 (Climate action): Using a fourth industrial revolution digital platform, with paperless technology, the project contributes to environment and climate protection and sustainability.
4. Objective 17 (Alliances to achieve the objectives): The project has coalitions with government, profit, and nonprofit organizations and with universities that promote sustainable business development.

[4] United Nations (2015)

The project received several recognitions, namely, Special Recognition for Social Impact ($25,000), Special Award for Innovation in Health ($25,000), and the First Place of EnterPRize 2020 ($25,000 plus sponsorship of over $20,000 for press and digital media promotion).

A Social Product

We never imagine conceptualizing health as a social product. It was in the courses of Health Promotion (EDSA 4020, 3 crs, 54 hours) and Social Determinants of Health (EDSA 4054, 3 crs, 54 hours) where our beliefs began a less than a year transformation. On the one hand, health is a product of various biopsychosocial determinants that work – and are even reinforced – in and from each society's cultural and sociopolitical framework. On the other hand, health is the focus of health promotion strategies and actions, aimed at helping people gain access to favorable health conditions.

Another reorganized scheme was our health concept as a universal right, in front of our health ideas as a product. The learning challenge was to assimilate that the right to health for all does not conflict with marketing strategies for health as a social product. Analyzing health situations as a social product manifestation generated by various biopsychosocial determinants was a learning must.

Another mental experience reshuffle was with the Mental Health Promotion course (EDSA 4055, 3crs, 54 hours). Mental health is also a social product of biopsychosocial determinants. COVID-19 pandemic measures have worsened the panorama. Some of us are health professionals in other areas (therapists and imaging diagnostic technologists). Having to decide whether or not to go home after a workday so our loved ones may remain contagion protected and having to consider whether or not to work for fear of contagion and face an economic crisis due to lack of income have our mood and emotional health distressed to cope with life, studies, and work responsibilities. Health promotion is more than focusing on a variety of health elements. The work involves social marketing strategies where the final goal is the sustainable health social product by the same biopsychosocial determinants of health.

Team Players in Cooperation

Our metamorphosis has allowed us to understand the need to practice teamwork, as a key learning for health promotion, without diminishing theoretical learning importance. The collaborative task method is one of the curriculum didactic pillars, because better health promotion actions come from teamwork. Being exposed to collaborative task method makes us easily learn different roles of a team player and how to interact with people of different health, science, and marketing branches.

From a collaborative method, we learn to learn, learn by doing, and learn to do and to function alongside with the other team members. It is from the whole and in cooperation that health promotion efforts can achieve transcendental goals regarding the social determinants of health.

No One-Way Communication and No One Size Fits All

Recognizing human diversity and preventing our stereotypes from affecting health promotion work have been another's reorganized skills. The practical experiences are that unique space to learn to be tolerant when working with diverse populations. We recall a practice when a follow-up call was made as part of a prevention diabetes program. Once connected, follow-up was provided, but we also listened to the person in their concerns. At the end of the call the patient appreciated the go in for and aiding during the call. It cannot be a mechanical communication with the same script for all because we would be denying that behavioral changes are a cultural, social, and economic process.

As a result of the COVID-19 pandemic, we have thought about people receiving and assimilating messages carried as part of a promotion. Communication in Public Health course (EDSA 4050, 3crs, 54 hours) made us aware of these considerations. Communication is not a mere signal that travels to an inanimate or senseless receiver. Communication is a social and political process where cultural interwoven discourses are produced, exchanged, and negotiated based on a common historical life. By studying the Ottawa Charter,[5] we became aware of communication as a social practice strategy for health promotion. Communication goes to interpretive, social, and cultural modes to create a public atmosphere for change behaviors, participation in innovation, and healthy and sustainable growth and development. Communication motivates and mobilizes action, which is instrumental to health promotion.

In Practical Experience II (EDSA 4158, 2crs, 36 hours), we took part in the vaccination clinics organized by the Medical Sciences Campus and by the Coalition of Vaccination of Puerto Rico, VOCES. We educate about the vaccination process, types of vaccines, and secondary effects and clarify doubts and questions from the patients who attended the vaccination. We met many 65-year-old people in need of a simple and carefully spoken language to understand the importance of vaccination against COVID-19. We could see how health promotion strategies may be available in many ways, without being aligned to people's learning needs.

Health promotion requires communication as a process, not as a campaign. Promotion depends on interpersonal, interactive, and media community participation, when studying, designing, and giving messages. The health communication needs to be segmented, instead of being massive like a one size fits all, and the

[5] PAHO (1986)

promotion should seek a deep social awareness of problems and its solutions, instead of focusing on persuasion for short-term behavior changes. True health communication promotion stimulates rigid structure transmutation (*morph*/metamorphosis) – which function in an automated way – to create progressive and sensitive changes with active people participation.

Praxis with Passion, Heart, and Theoretical Foundations

Through the courses of Educational Process in Health Promotion and Education (EDSA 4013, 4crs, 72 hours) and Foundations of Interventions in Health Promotion and Education (EDSA 4051, 3crs, 54 hours), we uncovered learning-to-learn strategies – learn to self-knowing and learn to apply theories to the behavioral change process. Health promotion requires passion and heart performing, but practice must be theoretically founded and aligned with involved population needs and its health promotion goals.

By reviewing different learning and behavioral change theories, we discovered what we can do as promoters of health. Maslow's hierarchy of needs theories,[6] Urie Bronfenbrenner's ecological systems theory,[7] and Howard Gardner's theory of multiple intelligences[8] have been central to our learning about health promotion, although there are other theories that have complemented us.

Maslow's hierarchical needs theory allowed us to appreciate the individual health status development from the different levels of interaction at hierarchy. Our health concept left behind the belief that health is the total absence of disease. Health is a complete state of physical, mental, and social well-being, where we can also add spiritual health to the Maslow hierarchy. The right to full self-realization as a marketable health product also corresponds to the optimistic humanism of Carl Rogers.[9]

In a practical intervention in the EDSA 4158 course, we applied the humanism of Rogers and Maslow. We faced the challenge of misinformation of a diabetic group of patients, to read and understand nutritional labels of food. Patients between ages of 55 and 70 years, mostly, and some between 30 and 35 years, could not distinguish between trans-fat and fat-free, sugar-free and no sugar added, total carbohydrate and total sugars, for example, and they also couldn't calculate calories and grams of nutrients to be consumed based on the portion or labeled serving size. Literacy over information reading and interpretation on food labels is one of the factors that determine how people make decisions about what they select to eat. According to humanists, adults build learning around their needs, based on the relevance and meaning that learning has in their daily events. We highlighted

[6] Quintero Angarita (2007)

[7] Guy-Evans (2020)

[8] Mercadé (n.d.) and Chura et al. (2019)

[9] Quintero Angarita (2007)

meaningful learning to co-build motivation of controlling and reducing external threats that arise to diabetics blindly eating foods with excessive sugar levels, saturated fat, and high sodium preservatives.

Rogers and Maslow's paradigms complement well with other studied theories such as Lev Vygotsky's social constructivism, Albert Bandura's social cognitive learning theory, and Jean Piaget's theory of learning. Learning is a cognitive structure reorganization via relevant satisfaction of each developmental stage's needs.[10] From Piaget's paradigms, health promotion must take advantage of the effect that the perception of visual elements and graphic symbols has on meaningful learning. This is important in planning and developing promotional visual and symbolic content. Bandura's vicarious learning theory makes us think that even health promoters, themselves, are models from which patients and people can learn vicariously.

Urie Bronfenbrenner's ecological systems theory[11] caught our attention because of its relationship to biopsychosocial determinants. This theory makes planning easier for us by recognizing that behavior is not just individual. A person's living environment conditions their behavior, and this could even be beyond the scope of health promotion. The ecological system is a stratified relationship of interpersonal, spatial, and chronological coalitions involving a variety of services to get health equity. In each stratum – individual, group, community, etc. – different theoretical approaches may be implemented to promote good health necessary changes. The scheme of the ecological systems makes it easier for us to integrate other theoretical models. Howard Gardner's theory classifies eight types of multiple intelligences[12]: naturalistic, interpersonal, intrapersonal, kinetic, musical, spatial, mathematical, and linguistic. A health promotion intervention could provide experiences that may appeal to more than one intelligence at the same time. The ecological system – being nonlinear – can also be complemented with Prochaska and DiClemente's model of transtheoretical change[13] and with Vygotsky's constructivism.

All theories are important in the professional training of health promoters. Considering human and cultural diversity, the promoter needs to master a variety of paradigms to adjust his/her interventions according to differences in learning and ability to make decisions and adopt new behaviors.

Reflective Appraisals: Creative Acts of Knowledge and Learning

Several significant evaluation strategies predominate as part of our preparation process:

1. Critical analysis of interview reports to health educators.

[10] McLeod, S. (2019)

[11] Guy-Evans (2020)

[12] Mercadé (n.d.)

[13] García-Allen (2015)

2. Introspective essays on the knowledge that we are building (from the integrated analysis of the world declarations on health promotion).
3. Analysis and immediate feedback based on different rubrics, according to the types of work carried out (research proposals, promotional interventions, health promotion plans, etc.)
4. Critical reviews of maps and flowcharts developed with online programs (Inspiration, Google Docs, Sketch.io).
5. Critical reviews of forms created through SurveyMonkey and Google Forms.
6. Periodic review of our progress toward professional competencies, based on what we have documented in our electronic portfolios.

At first, most of these strategies confused us, and we seemed to float through an eternity of thoughtful rehearsals and remote teamwork, which was even more complicated. We question the usefulness of these assessment strategies. Through systematic review of our assignments, first, changes appeared in our feelings and way of thinking, and we began to understand. We are witnesses of our metamorphosis, on a personal level as in our professional skill development. Table 46.1 includes activities and learning achieved after the first year of studies, for nine of the 13 competencies.

We cannot establish which strategy has had a greater impact than another in the evaluation of learning, but we can mention a key element that stands out in all of them: participatory dialogues with teachers. Many occur within a group, where it is not just about speaking or giving an opinion. We contrast the knowledge that each one is creating and how we perceive and interpret the experiences against the study content. The gear of this dialogic participation with our professors has been the engine to learning to learn about diversity in teaching and learning and about participatory action as social value to society and collective life. By actively participating in assessment strategies, we seize meanings and social and professional practices, essentials for working with health promotion.

The different forms of reflective and critical appraisals turn out to be, in themselves, creative acts of knowledge and learnings that test our ideals and ways of thinking. One of the most shocking and challenging issues for us was considering health as a product that can be promoted, working on the interrelation of factors that involve the participation of society sectors, which do not even belong to the health arena. Among all the statements discussed and evaluated, the Ottawa Charter[14] was key to this learning. Alma Ata's declaration anticipated several of the Ottawa Charter principles by referring to health as a human right that needs government and other social sectors' protection, since it is a shared responsibility. But his focus was on primary health care as the first level contact of people with the health system. Although Alma Ata includes the promotion concept as part of the primary healthcare services, its mention was linked to government's obligations regarding the provision of food, drinking water, immunization, treatment of diseases, and provision of essential drugs, among others.

[14] PAHO (1986)

Table 46.1 Activities and learning achieved after the first year of studies, for nine (9) of the (13) competencies

Professional competence	Tasks and activities performed	Learning achieved
Plans and implements the assessment of needs, resources, and capacities in promotion and education for health	Profile community study in Loíza municipality	Record of the need for essential services in Piñones, Loíza, to enjoy good health
Examines the relationships between behavior, environment, and genetic factors that enhance or complicate health	Exploratory research around the stigma toward people with COVID-19 Bioethics and scientific advances introspective essay	Examine disease relationship to ethnic, nationality, and geographical origins and its affecting factors and consequences Importance of research in real scenarios, to substantiate tools and strategies Substantiate positions around conflicting issues not thought of before (scientific advances that have been made outside the principles of bioethics)
Examines the factors that influence the learning process and therefore the process in health promotion and education	Educational intervention in nutrition and dietetics with older adults	Apply a humanistic approach to the education process
Develops goals and objectives for intervention strategies based on assessment findings	Mental health educational intervention for our group as students Instructional module design Structured booklet for educational intervention	Objective's revision based on Bloom's taxonomies and under the SMART rules (specific, measurable, actionable, relevant or realistic, and time bound) Provide for all types of learning and anticipate what would be essential in an educational intervention planning and design
Select or design strategies and interventions aimed at individual and social changes that impact health	3- to 5-year-olds' oral health educational intervention	Reinforce knowledge about how children learn; find high-quality template resources and work as a team
Create and develop an assessment/research plan	Exploratory research on stigma toward people with COVID-19	Research basic parts and the importance of a good literature review to support the bases of the investigation Educator's role with science, research, and the foundations for health promotion work

(continued)

Table 46.1 (continued)

Professional competence	Tasks and activities performed	Learning achieved
Design simple data collection tools	Create instruments using SurveyMonkey and Google forms and configure them in excel	How to write questions and choose those that are relevant to the information you want to collect Learn about different types of questionnaires and how to create them Considerations on excel statistical operations with previously designed instruments
Facilitates partnerships for health promotion and education	Student Committee for the Promotion of Global Health, at IIPESAG	Teamwork to participate in activities that address issues that affect global health
Identify, develop, and deliver messages using a variety of communication strategies, methods, and techniques	Public health communication plan, segmented by age groups Virtual dissemination of #yomelapongo #nomelaquito Use of masks promotion through IIPESAG	Steps to follow when conceptualizing a communication plan Basic parts of a communication plan and its relation to a social marketing program Establish objectives for changes in behaviors, following the SMART rules Specify communication products and distinguish them from the channels that will serve as a medium for the messages Design promotional materials and apply rules of simple and clear language, and whose understanding corresponds to the literacy of an eighth-grade level of school

It was not until the Ottawa Declaration that health promotion was conceptualized as the new public health for the world, and it was this declaration that impacted our health concept and health promotion working ideas. Health promotion entails structural changes at social, economic, and cultural level to reduce health disparities and to make possible the means and processes for individuals to improve their health. Everyone is responsible for this goal, which is the core of Alma-Ata's expression at the 1978 PAHO meeting. We wonder if it would be necessary to provide basic training on health and health promotion concepts in those elected to political positions, due to these unavoidable responsibilities.

Ottawa also included the health literacy principle to increase knowledge and improve social skills to make decisions and take control of health. For us, this was

another new concept. Learning about it made us revise assumptions that remained ignored for a long time. We cannot assume that people have mastery of skills to read sentences and paragraphs, interpret data in various formats (tables, figures, graphs), and understand information that requires mathematical operations for its interpretation.

Similar content in health promotion objectives is in Jakarta and Shanghai Declarations.[15] Although paraphrasing, both statements are consistent with the objectives of the Ottawa Charter but break down specific health promotion practices to achieve the objectives.

The critical dialogue between us and our professors, actively listening to us when discussing constructed knowledge and results of the papers presented, is the most powerful assessment we can receive to move us to embrace the discourse on the discipline of health promotion.

Learnings for the World and for Puerto Rico

Health and health promotion concept definitions are applicable to the entire world. Since the Ottawa Charter, these concepts remain in force and are guidelines for global health quality. Communication, empathy, respect, teamwork, learning to lead and be led, and undertaking as an agent of change are universal skills that can be learned and make health literacy affordable. Paradigms such as constructivism, vicarious learning, transtheoretical change, and ecological systems are culturally sensitive, so they can be applied very well in different world settings. Health advocacy learning is also possible, because people are the main actors regarding the changes that their behaviors and lifestyles require to achieve better health.

The people of Puerto Rico can learn from our experience that building health-friendly environments begins with one as a person. Each of us can be the change promoter in favor of health. This implies that health promotion must include intensive education and training processes, consistently, so that people:

1. Re-evaluate wrong beliefs about health concepts to promote the establishment of its holistic emphasis at all levels.
2. Learn to develop learning communities where they can recognize social, economic, and cultural factors that need to be changed to take control of the determinants of health.[16]
3. Learn to participate in constructive dialogue teams that move individual and collective wills to adopt healthier life choices.
4. Learn about law and policy making, public debate, and media advertising rules, to effectively participate in policies for reducing disparities in health.

[15] OMS (2016a, b)

[16] Departamento de Salud de Puerto Rico (2020)

5. Learn to be at the center of advocacy and decision-making processes. Because of Puerto Rico circumstance as territory of the United States, the development of this fearlessness will require a lot of practical training in leadership, assertiveness, access to key resources (as organizations and communities with experience in political-community actions), and openness to official documents with information on the conditions of relations between the United States and Puerto Rico. Having emulated systems that were not designed for our social, economic, and cultural needs has resulted in a gap between what we can achieve and what we have done, in addition to the significant cost of these decisions. Some health promotion actions in Puerto Rico fall into a zone of sensitive activity, where there are issues whose decisions have been the exclusive domain of the United States, without the broad and effective participation of the people. Examples of these decisions that affect healthy life opportunities are as follows: access to healthy foods locally produced at reasonable prices compared to imported foods, development of legislation and active supervision on the use and consumption of unhealthy products, availability of transparent information on preparedness to mitigate and recover from national and local emergencies, and equitable access to basic education and health promotion services, regardless of the type of insurance that Puerto Ricans have.
6. Learn to discover and raise awareness about biopsychosocial determinants and how they are leading us in the opposite direction to the most complete state of health. We must move from pale actions to forceful actions to take control over the following determinants:

    - Sustainable management of domestic, commercial, and industrial waste to protect our environment.
    - Ensure safe, fair, and healthy working conditions for all workers.
    - Participatory and well-active inclusion of people with disabilities in political decisions and changes conducive to enjoying the universal right to health.
    - Protect the "third sector of health services" – nongovernmental organizations – from bureaucratic actions that delay their planned services and, consequently, their projected achievements.

Every person and each sector of the society, being public or private, can be facilitators of the necessary resources, so that in an individual and in a collective action, it is possible to develop our maximum health potential.

Table 46.2 brings our reflection on the six triggering questions suggested by the editors.

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Table 46.2 Authors' reflections on the six triggering questions suggested by the editors

Questions	Take-home messages
What is our vision about HP?	Health promotion is a set of educational, environmental, and social actions and strategies that promote an active role in decision-making for a better quality of life. It has the power to reach a great diversity of people and to empower the patient, family, groups, community, and society in general and to promote the achievement of healthy and sustainable development goals worldwide. Health promotion considers the specific health literacy needs of each population in the world. Before studying health promotion, some of us believed that the privatization of health services was the economic option. But the fair and balanced quality of life should not be subject to economic adjustments. A balance is required between public and private health service companies, because we all have the right to enjoy good health
What is the institutional and political context of your experience (participants, professions and courses involved, duration and frequency of activities)?	We are students of health education and health promotion baccalaureate, in the medical sciences campus of the University of Puerto Rico. The UPR is the US commonwealth of Puerto Rico public university. We have completed nine concentration courses (468 hours). The practical experiences have been fundamental to see from reality what health promotion is. We have shared with students of health sciences administration, physical and occupational therapy, veterinary technology, and medicine. We are members of the student Committee for Global Health Promotion of the research Institute for Global Health Promotion and Health Education. Some of US are social media managers, web page and network content creators, and collaborators in the development of health promotion materials, together with a group of doctors and mental health specialists. We have also participated in the UPR COVID-19 vaccination center assisting people to complete the required documents for the Centers for Disease Control and Prevention
Which theories and methodologies are used in the teaching-learning process?	Maslow's hierarchy of needs theories, Urie Bronfenbrenner's ecological systems theory, and Howard Gardner's theory of multiple intelligences have been central to our learning. Health promotion requires a biopsychosocial approach and recognizes that there are diverse social environments that influence human needs and the types of intelligences that may manifest themselves. The responses of the individual to these influences are in tune with Maslow's postulates about how motivation and the will to adopt behaviors that enable the satisfaction of human needs in a hierarchy intervene. It has been common in our courses to build and deconstruct knowledge through the development of active tasks and collaborative, reciprocal, and theoretical-practical learning. The focus is that we must learn to learn, learn to do, learn to live together, and transform ourselves and our society, thus facilitating meaningful, purposeful, and pertinent learning to our comprehensive professional development rooted in the same principles of health promotion

(continued)

Table 46.2 (continued)

Questions	Take-home messages
What forms of assessment are applied, results achieved, and challenges faced?	As significant we can mention critical analysis of interviews with health educators, essay reviews on our knowledge building, analysis of rubrics' application to research proposals, the design of promotional materials based on a health communication plan, and critical reviews of concept maps and flowcharts made with online programs as well as reviews of SurveyMonkey and Google forms created. The critical dialogue and social participation between us and our professors, reviewing our electronic portfolio and our performance in practical experiences from the beginning of the studies, are what most powerfully contribute to our embracing and welcoming the discourse on the discipline of health promotion. The curriculum has 13 professional competencies to be achieved. In 11 of those we are partially or quite developed. Among the challenges faced because of the assessments, we have had to break mental schemes, previous beliefs, and conceptions to co-build new pathway connections on health promotion
Which principles, pillars, competencies, or approaches to health promotion do you base your plan of teaching and learning?	The Ottawa charter and the three pillars of health promotion established by the World Health Organization (WHO) since 2016 have been key: Good governance and policies for choosing healthy, accessible, and affordable options; healthy cities with an environment that allows living, working, and having fun in harmony and good health; and health literacy (improving knowledge and social skills) to help people make decisions that favor health. Some core competencies for the learning process have been organization, punctuality, respect, empathy, communication, flexibility, teamwork, learning to lead and be led, and to undertake and maintain the mentality of being a change agent. The world requires these skills, and it is necessary to develop and apply them in our training and for the common good
What others could learn with your experience? What is localized, and what is "generalizable"?	The people of Puerto Rico can learn from our experience that building healthy environments begins with ourselves. Each one of us can promote the change that you want to see in your environment and be facilitators of the necessary resources to contribute to a world with greater equity and health. It is necessary to empower the third health sector and recognize that we must be active in the policies of our country. Communication, empathy, teamwork, and undertaking as an agent of change are skills that can be learned, which serve as a bridge to promote health promotion and make affordable health literacy and healthy life choices in support of the environment. The focus of work in health advocacy is also that people are the active actors regarding the changes that their behaviors and lifestyles require to achieve better health

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