

Health promotion capacity building

An exploratory study of the Norwegian health promotion workforce

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Thesis submitted in partial fulfilment of the requirements for the degree

Master of Philosophy (Health Promotion)

University of Bergen, 2012

Acknowledgements

First of all I want to say thanks to everyone who was onboard in selecting me for admission to the studies. It has been a great learning and living experience!

For allowing this thesis reach the current state I owe thanks to a lot of people:

To my supervisor Professor Elisabeth Fosse- thanks for guidance, comments and encouragement throughout the entire project. Your warmth and always positive attitude has healed my anxiety of professors.

To all the informants of this study- thanks for making this project possible without getting anything in return.

To my friends Jorunn Grete Sortland and Annette Kathinka Servan- thanks for proofreading my translations over and over again. Each of you is getting a big cake soon!

Last, but not the least, thanks to the little life in my belly for literally kicking me to move forward. And for my husband, thanks for trying not to do the same!

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Abstract

Introduction. The international Union for Health Promotion and Education highlights that “developing a competent Health Promotion workforce is a key component of capacity building for the future and is critical to delivering on the vision, values and commitments of global Health Promotion” (1). Until now there is a lack of data to what extent health promotion education leads to health promotion practice both locally and globally. This master thesis is a report of an exploratory mixed method study discovering issues and challenges that graduates of the Norwegian programs of health promotion experience in the labour market.

Methods. The study was performed in two steps, where the first one was an online questionnaire and the second step contained telephone interviews. Mixing methods allowed us to get an overview of what positions and type of contracts health promotion professionals are employed at, as well as get a deeper understanding of what it means to be a health promoter in various circumstances in Norway.

The results of step 1 showed that the employment rate was about as high as after completing other study programs in Norway - 97 %, but in terms of relevance- only 65% could say that they do health promotion/use health promotion education at current workplaces.

Public health coordinator, advisor, leader and other similar positions are the ones where health promotion education is utilised the most- four of five respondents working at these positions marked that they use the education continuously or often. However, only half of them (59%) had a permanent job contract.

Other positions where health promotion graduates could utilise their education were: teachers, nurses, therapists and etc. But in these positions not everybody had possibilities to utilise their health promotion education. The main influencing factor to what extent health promotion graduates can use their education at work was the stakeholders (employers).

The most challenging tasks at the current workplaces of health promoters were mostly related with project management and other administrative tasks.

The interviews revealed high demand for the IUHPEs standards for health promotion education and wider spread of the competencies that it provides to the society. There is a need for better communication between institutions providing health promotion education and the job market.

Conclusion. This study provides the wide angle picture of how health promotion is utilised in the labour market and identifies some issues that are influential in practice. Yet, this study aimed to give an overview of the current situation, and therefore can not provide a lot of details, but calls for further research on identified issues.

Norsk sammendrag

Introduksjon. International Union for Health Promotion and Education fremhever at "å utvikle en kompetent helsefremmende arbeidskraft er en viktig del av kapasitetsbygging for fremtiden, og er kritisk for å kunne levere i tråd med visjonene, verdiene og forpliktelsene til global helsefremmende arbeid" (1). Inntil nå mangler det data på i hvilken grad en helsefremmende utdanning fører til helsefremmende praksis lokalt og globalt. Denne masteroppgaven er en rapport av en eksplorerende mixed- metode studie med mål om å kartlegge problemer og utfordringer nyutdannede fra de norske studieprogrammene i helsefremmende arbeid opplever på arbeidsmarkedet.

Metode. Studiet ble utført i to trinn, det første med nettbaserte spørreskjema og det andre med telefonintervjuer. Blandingen av metoder tillot oss å få en oversikt over hvilke stillinger og type kontrakter helsefremmende fagfolk er ansatt ved, samt få en dypere forståelse av hva det innebærer å være en helsefremmer i ulike situasjoner i Norge.

Resultatene fra trinn 1 viste at sysselsettingen var omtrent like høy som etter fullført andre studium i Norge – 97 %, men i forhold til relevans kunne bare 65 % si at de gjør helsefremmende / bruker helsefremmende utdanning på nåværende arbeidsplass.

Utdanning innen helsefremmende arbeid ble mest benyttet i stillinger som folkehelsekoordinator, rådgiver, leder eller lignende. Fire av fem respondenter med slike stillinger svarte at de brukte utdanningen kontinuerlig eller ofte. Likevel hadde bare halvparten av dem (59 %) en fast arbeidskontrakt.

Andre stillinger hvor nyutdannede helsefremmere kunne utnytte sin utdanning var blant lærere, sykepleiere, terapeuter og etc. Men dette gjaldt ikke alle med denne typen stillinger. Arbeidsgiverne hadde ulike perspektiv på hvor vidt en helsefremmende utdanning representerte en ressurs for arbeidsplassen eller ikke. Dette syntes å være den viktigste faktoren i forhold til hvilken grad helsefremmere fikk bruke sin utdannelse på jobben.

De mest utfordrende oppgavene på de aktuelle arbeidsplassene var hovedsakelig knyttet til prosjektledelse og andre administrative oppgaver.

Intervjuene avdekket stor etterspørsel etter IUHPEs standarder for helsefremmende utdanning og en bredere spredning av kompetansene det gir til samfunnet. Det er behov for bedre kommunikasjon mellom institusjoner som tilbyr helsefremmende utdanning og arbeidsmarkedet.

Konklusjon. Denne studien gir et vidt bilde av hvordan helsefremmende arbeid utnyttes i arbeidsmarkedet og identifiserer noen viktige problemer i helsefremmende praksis. Likevel, hensikten med dette studiet var å gi en bred oversikt over dagens situasjon, og kan derfor ikke bidra med mange detaljer. Videre forskning på de identifiserte problemområdene er derfor nødvendig.

1. Introduction

1.1 Introduction to the problem

Health promotion education is a part of health promotion capacity building (2) but to what extent it actually leads to health promotion capacity growth is unknown - knowledge on how professional education is utilised in practice is limited.

There seems to be a consensus in Europe that health promotion education is in need to be standardised in order to ensure effective health promotion practice (3). For workforce training to be effective, emphasis must be placed on the wants and needs identified by currently employed professionals (4). Knowing what issues or challenges in health promotion workforce are related to gained education in each country might help to build and improve professional standards and build effective health promotion capacity. Therefore this study aims to increase this knowledge by exploring how graduates of the Norwegian study programmes of health promotion utilise their education in daily work practice.

1.2 Research question

How health promotion education is utilised at the current workplaces of the graduates of Norwegian study programmes of health promotion?

The word *utilised* is here used as an umbrella verb covering these questions:

- How many graduates of Norwegian health promotion programmes get a job related to health promotion? What jobs are related to health promotion?
- What are the challenges that the graduates of Norwegian programmes of health promotion experience at their current workplaces?
- How health promotion knowledge is put to practice in different work settings?

2 Literature review

This chapter aims to provide a short overview of the recent studies related to health promotion education and workforce globally and in Europe as well as cover what is known about the current situation of health promotion education and workforce in Norway.

2.2 Main definitions

2.1.1 Capacity building in health promotion

There are many different definitions of capacity building in health promotion literature. In this study the definition of capacity building is understood as “the development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion” (5). It involves actions to improve health at three levels, and this study focuses on one of them- the advancement of knowledge and skills among practitioners.

2.1.2 Norwegian health promotion workforce

One of the main challenges to map health promotion capacity is how to count the health promotion workforce, when health promotion work is done by many different professions (3,6). The objects of this study are graduates of bachelor or/and master degree education in health promotion or public health. Public health (Norw. folkehelse) in Norway is concerned with the development of a community that facilitates positive health choices and healthy lifestyles; promoting safety and participation for the individual and good conditions for children and youth; and preventing disease and injury (7). Therefore graduates of the Norwegian public health programs are included in the study and are further on called graduates of Norwegian health promotion programs.

2.3 Mapping health promotion capacity

“Developing a competent Health Promotion workforce is a key component of capacity building for the future and is critical to delivering on the vision, values and commitments of global health promotion” (8, p.5)”.

In order to develop a competent health promotion workforce it is important to map the current capacity and evaluate its’ needs. There is no single or best way to map health promotion capacity, but doing it is vital to developing capacity for health promotion (6, 9). This study is focusing on one level of capacity building - the advancement of knowledge and skills - and the objects of the study are therefore the graduates of the Norwegian health promotion programs. Until now, very little is known about the challenges that health promotion practitioners experience after they complete their education (4). Barry M. (2008) had set open questions about health promotion education and its adequacy to handle future challenges of a constantly changing health promotion climate (10).

“Are the HP students who are being trained today being equipped with the necessary skills and knowledge for policy and practice development over the next 20 years?”

To what extent are current HP curricula responsive to the needs of practitioners working in diverse cultural settings?” (10. p.57)

Since the health promotion workforce consists of interdisciplinary professionals (11, 12, 13), it makes it difficult to synthesise research in this area. In many countries health promotion work is part of tasks of public health specialists and health educators (11). The author of this thesis was able to find only one study where the objects of the study were professionals with a title “health promoter”, or graduates of programs named “health promotion”. The overview

below includes studies that analysed needs of public health specialists, health educators and health promoters.

A few studies focusing on health promotion workforce needs took place in Columbia, Australia and New Zealand. Those studies focused on practitioners working in health promotion regardless of their education (14, 15).

Limited information exists about the employment status of students who completed public health programs in Australia (16). In 2000, the Australian institute of primary care studied the preferences for continuing-training needs of health professionals (15). The study showed that all health promotion professionals have needs in health promotion evaluation and research, 98 % expressed the need for deeper knowledge in strategies to change organizations to facilitate health promotion. Health promotion specialists expressed the least interest in health promotion models and theory (87 %) and strategies for particular illness groups (85 %). Interestingly, the study only focused on getting an overview of what training preferences health professionals have in different sectors. There was no discussion on why health promotion specialists expressed so high needs (at least 87 %) for continuing-education (15). In 2001, Allegrante et al. studied the American workforce of public health and concluded that all public health professionals needed at least some of the continuing education (14).

One study examined the German health promotion workforce by tracking former health promotion students of one university. The study was conducted in 2003 (n=144), 2006 (n=83) and 2008 (n=39). They documented how soon and what positions former students got after completing their education (17). The results of that study revealed that the biggest employers

of their graduates were health insurance funds and universities. It is interesting to note that the numbers varied highly when results from different years were compared (17).

The findings of this study were not published in any international journal, and were obtained through the author's personal contacts. It is possible that similar studies were done in other countries, but results were not published or only published locally and therefore cannot be found.

There is a clear need for more studies that contribute to the global need of health promotion mapping and capacity building. Also, there is lack of studies on how health promotion education leads to good health promotion practice. It seems to be problematic that studies may have been done but have not been published and therefore cannot contribute to developing knowledge and good practice worldwide.

2.4 European projects contributing health promotion capacity building

The International Union for Health Promotion and Education (IUHPE) is an association of individuals and organisations committed to improving the health and wellbeing of the people through education, community action and the development of healthy public policy (18). With three major goals: to advocate for health, to improve effectiveness, and to build capacity The IUHPE develops collaborative projects, both at global and regional levels (19). The CompHP and the HP-source net are two collaborative capacity building projects where the IUHPE European office is a partner or a collaborator (5, 20).

2.4.2 The CompHP project

The CompHP - Project 'Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe' began in September 2009 and is scheduled to run

until August 2012. The project aims to develop competency-based standards for Health Promotion that will impact on workforce capacity to deliver public health improvements in Europe. In order to strengthen a global commitment to improving health promotion practice - moving towards global consensus regarding competencies, standards and quality assurance systems will be necessary (5,13)

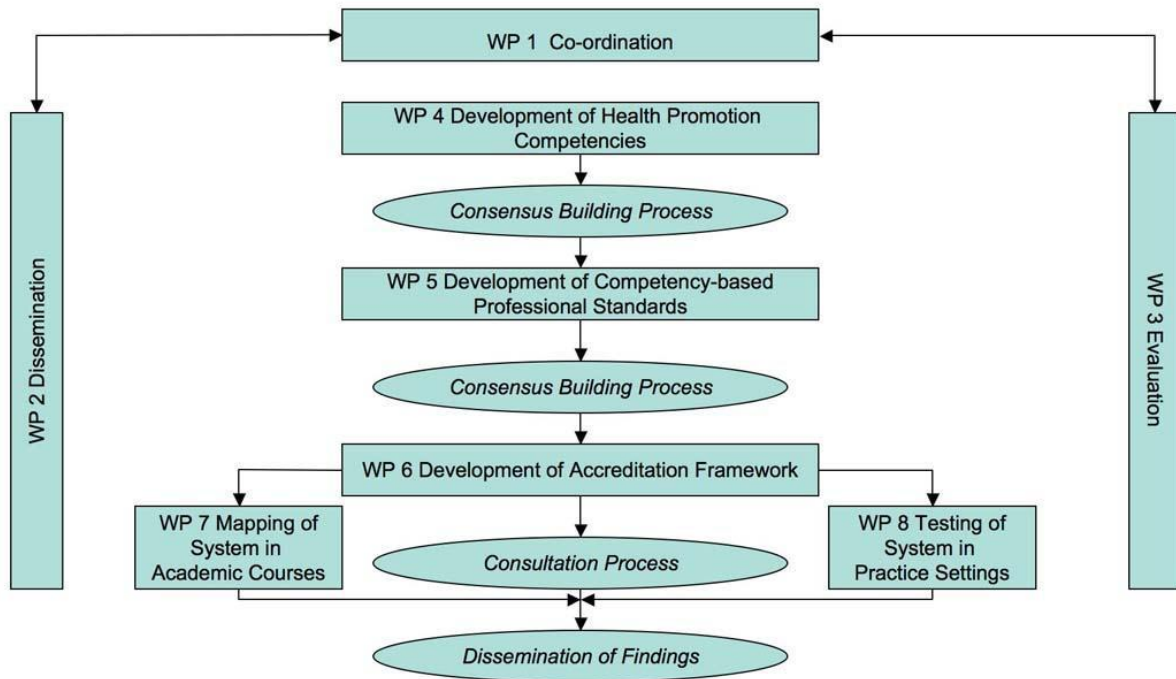


Figure 1. A structure of the CompHP project (3)

Work package 4 – Development of Health promotion competencies - in March 2011 had published “The CompHP Core Competencies Framework for Health Promotion Handbook” (5) which has provided a conceptual framework for this study. Since health promotion “is a dynamic and evolving field” and the publishers recommend to review and revise these competencies every five years (2).

Work package 5 – Development of competence based professional standards for health promotion also provided one handbook - The CompHP Professional Standards. It was designed

for use by practitioners and employers as well as professional associations and trade unions with a responsibility for health promotion practitioners, development of education and training programmes supporting health promotion practice (21). It is built on earlier published core competencies and not only states what a health promotion practitioner must be able to do, but also what knowledge and skills are required for each competency domain (Figure 2) (21).

The Professional Standards handbook states that health promotion practitioners “*must be able to meet all the standards, and at all times act professionally and ethically*” (21, p.13), and were later on (11) criticised for being “*too ambitious*” (11, p.79). One of the comments concerning these standards in the work package 7 was:

“The standards are too demanding. Only few experts would fully qualify on all points, and only few would use all skills mentioned at such high level” (11, p. 78)

<i>Competency Statement</i>	Core Knowledge and Skills required:
<p><i>8.1 Use ethical, empowering, culturally appropriate and participatory processes to implement health promotion action</i></p> <p><i>8.2 Develop, pilot and use appropriate resources and materials</i></p> <p><i>8.3 Manage the resources needed for effective implementation of planned action</i></p> <p><i>8.4 Facilitate programme sustainability and stakeholder ownership through ongoing consultation and collaboration</i></p> <p><i>8.5 Monitor the quality of the implementation process in relation to agreed goals and objectives for health promotion action</i></p>	<p>Knowledge</p> <ul style="list-style-type: none"> - Principles of project/programme management - Principles of effective human and financial resource management including performance management and risk management - Theory and practice of programme implementation - Understanding social and cultural diversity - Quality assurance, monitoring and process evaluation - Theory and practice of community development including: empowerment, participation and capacity building <p>Skills</p> <ul style="list-style-type: none"> - Use of participatory implementation processes - Use of project/programme management tools - Resource management - Collaborative working - Ability to work with: groups and communities participating in the health promotion action; stakeholders and partners; team members - Monitoring and process evaluation

Figure 2. Knowledge and skills required for the professional standard 8. Implementation(21)

- **Work package 6 - Developing accreditation Framework** - Developing a sustainable pan-European accreditation system, that could potentially be facilitated centrally by the International Union for Health Promotion and Education /European Region (IUHPE/EURO) and operated at national level through designated national agencies. CompHP Pan European Accreditation for Health Promotion Handbook is to be published in autumn 2012 (21), but the draft is available now (11).
- **Work package 7 - Mapping of system in academic settings** - Relating competencies, standards and accreditation to education and training programmes across Europe, through mapping competencies against academic curricula and exploring accreditation of educational and training programmes (21).

- **Work package 8 - Testing of system in practice settings** - Testing the implementation of competencies, standards and accreditation framework in practice settings with a representative range of national agencies across Europe (18). Research done for this package showed overall support for the implementation of an accreditation system for health promotion and revealed what factors will impact on implementation in different countries in Europe (11).

2.4.1 The HP-Source.net project

HP-Source.net is a voluntary, international collaboration of researchers, practitioners and policy makers, having the common goal to maximise the efficiency and effectiveness of health promotion policy, infrastructures and practices by:

- Developing a uniform system for collecting information on health promotion policies, infrastructures and practices;
- Creating databases and an access strategy so that information can be accessed by policy makers, international public health organisations and researchers;
- Analysing the databases to support the generation of models for optimum effectiveness and efficiency of health promotion policy, infrastructure and practice;
- Actively imparting this information and knowledge, and actively advocating the adoption of models with proven effectiveness and efficiency by means of publications, seminars, conferences and briefings, among other means (20).

At the time of writing, HP-Source.net databases are available on topics Child Mental Health in the Southern Part of the Western Pacific including Australia and the surrounding regions, European Mental Health Promotion, European Alcohol Policy, National-level health promotion capacity mapping in Sub-Saharan Africa (data entry - 2008), and National-level

health promotion capacity mapping in Europe (data entry 2005-) (20). The databases are funded by various health promotion organisations and networks, which are also responsible for data entry and its' quality (12). The sponsors can be contacted by the users of databases for clarifications or further inquiries (12).

The HP-Source.net project aims to simplify the communication by institutions at European and National levels as well as by policy makers, international public health organisations and researchers working in the health promotion sector (13). HP-source.net provides links to health promotion institutions throughout Europe and the rest of the world (14). Unfortunately, it is unknown how the availability of this tool had affected communication between universities training health promotion professionals or any other institutions.

2.5 Health promotion education in Europe

According to the HP-source.net database sponsored by IUHPE European region “National-level health promotion capacity mapping in Europe” sub-topic “professional workforce” health promotion education is available at 33 countries in Europe, at all together 247 institutions (20). There are certainly more institutions and programmes preparing health promotions specialists in Europe. HP-source.net attempts to have every European country in the database (12), but many countries are still missing, as for example, the author’s home country. It is not in a database, but as to authors’ knowledge, there are at least four bachelor level programmes, that promise their graduates competence in health promotion practice.

Institutions that are in the database claim to offer higher education in health promotion, while programme titles, curricula, depth, teaching methods and entry requirements differ strongly(12,13). According to König “such diversity enriches health promotion, by producing

cadres of health promotion professionals with blended skills and experience needed to meet the wide array of health challenges in Europe” (12, p. 34).

2.6 Health promotion education in Norway

In Norway health promotion is not recognised as a profession (11). Health promotion education in Norway is available at different levels from single courses to master degree education and is organised by several teaching institutions in Norway. In 2010 all the universities and colleges responsible for health promotion education in Norway have formed *A National Network for Health Promotion*. Below is the list of institutions and programs that were included in this study. Abbreviated Norwegian names of the universities are given in brackets as in this form they are presented in the result section of this thesis.

- The University of Bergen (UiB) – is responsible for both bachelor and masters program in health promotion. The master’s program for international students is offered every second year. (22).
- The Vestfold University College (HiVe) - offers a part time master’s degree study in health promotion that is organised over four years (23).
- The Gjøvik University College (HiG) – together with the Lillehammer University College (HiL) and the Hedmark University College (HiHm) offers a master’s degree study in health promotion and community care. Later on in this master thesis names of these university colleges are abbreviated as HIGHL (24).
- The Norwegian University of Science and Technology (NTNU) offers master in psychology with specialisation in health care, organisational- and communication psychology. The research Centre for Health Promotion and Resources at the university

aims to become an internationally leading centre for health promotion and health resources research, program development and the communication of knowledge (25).

- The Norwegian University of Life Sciences (UMB) – together with Oslo University College offers a master's degree study in public health knowledge. Students of this study may choose an area of focus between environment, health, health promotion practice and activities (26).
- The Bergen University College (HiB) – offers three year bachelor's program in public health (27).

In their web pages universities inform about work possibilities after completed education.

These mostly include: public health coordinator, public health advisor, other advisor or leader positions, senior positions at patient organisations, work in schools, higher education and research as well as competence to work with project management, personnel management, planning and evaluation work (22-27).

However, the institutions responsible for health promotion education have no overview over how their graduates perform in the labour market. Studies focusing on graduate's employment profile are regularly performed by different universities, but these types of studies focus on all the programmes at once. They collect quantitative information on matters of current work, the transition between study and work, relevance of education etc. Such reports can not reflect on employment situation of separate programs like health promotion. For example, in the report of three Bergen universities (UiB, HiB, NHH) only 9 graduates of health promotion programs responded to the study (2). Generally obtained response rate varied from 39% till 64% (28, 29).

Here are some examples of employment profile studies recently performed in Norway:

- University of Bergen (UiB), Norwegian School of Economics (NHH) and Bergen University College (HiB) had performed a study in 2011 with graduates from 2009. They found that 65% had a permanent job, 25 % were employed in temporary positions, 2% were self employed, 2 % were unemployed. 57% had a relevant job, 94 % had a permanent job at the time of the study (28).
- The Norwegian University of Life Science (UMB) latest workforce study had been published in 2011 and included students that graduated 2005 – 2009. Results showed that 70% had a permanent job, 14% had a temporary position, 2% were unemployed at the time of the study. 87% of respondents had a relevant job, and 92% worked full-time (29).

2.7 Current political background regarding health promotion in Norway

The health promotion field is dynamic, constantly changing (10) and therefore it is important to show the situation in the political arena in the country where the study is done. The Norwegian Public Health Act (Norw. folkehelseoven) was passed by the Parliament in Norway in June 2011, and became effective from the 1st January 2012 as a part of The Coordination reform (Norw. Samhandlingsreformen ; Stortingsmeldingen nr. 47). (30,31).

The purpose of this Act is to contribute to societal development that promotes public health and reduces social inequalities in health. It shall promote the population's health, well-being and good social and environmental conditions by integrating health and its social determinants to all social and welfare development (30).

This Act places responsibility for public health as a whole-of-government and a whole-of-municipality responsibility rather than a responsibility for the health sector alone (30).

Participation and collaboration with stakeholders is an important aspect of good public health work and the Act shall ensure that all governmental organs coordinate their activities in the area of public health work (30). Structural reforms in municipalities will be done gradually, but some municipalities began changes already before the new laws were passed (31).

The Act is based on five fundamental principles that shall underpin policies and action to improve population health:

- *Health equity:* Health inequities arise from the societal conditions in which people are born, grow, live, work and age – the social determinants of health. Social inequities in health form a pattern of a gradient throughout society. Levelling up the gradient by

action on the social determinants of health is a core public health objective. A fair distribution of societal resources is good public health policy (30).

- *Health in all policies:* Equitable health systems are important to public health, but health inequities arise from societal factors beyond health care. Impact on health must be considered when policies and action are developed and implemented in all sectors. Joined up governance and intersectoral action is key to reduce health inequities (30).
- *Sustainable development:* Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Public health work needs to be based on a long term perspective (30).
- *Precautionary principle:* If an action or policy has a suspected risk of causing harm to the public or to the environment, the absence of scientific consensus that the action or policy is harmful, cannot justify postponed action to prevent such harm (30).
- *Participation:* Public health work is about transparent, inclusive processes with participation by multiple stakeholders. Promotion of participation of civil society is a key to good public health policy development (30).

Even though the Act is called Public Health Act, its principles and the main points seem to be based on the main document of the health promotion field – The Ottawa Charter for health promotion. Without explicitly mentioning the Ottawa Charter or health promotion the Act acknowledges that responsibility for people’s health goes beyond the health care sector, and ensures creating supportive environments and adapting them to local needs. The public health in Norway is not a part health sector that is responsible for disease prevention, oppositely- health sector, health promotion and disease prevention are interrelated parts of the public health.

2.8 Conceptual framework

This study aims to contribute to health promotion capacity building in Norway by mapping health promotion professionals that graduated from the Norwegian health promotion programs. This study is focusing on how health promotion education is utilised in the Norwegian health promotion workforce. Among other objectives this study was analysing to what extend health promotion strategies are employed and activities are performed in the everyday work of graduates of the Norwegian health promotion programmes. The conceptual framework for this study is the CompHP competency framework published in February 2011 (Figure3). It was used both to develop questionnaires and to analyse the data.

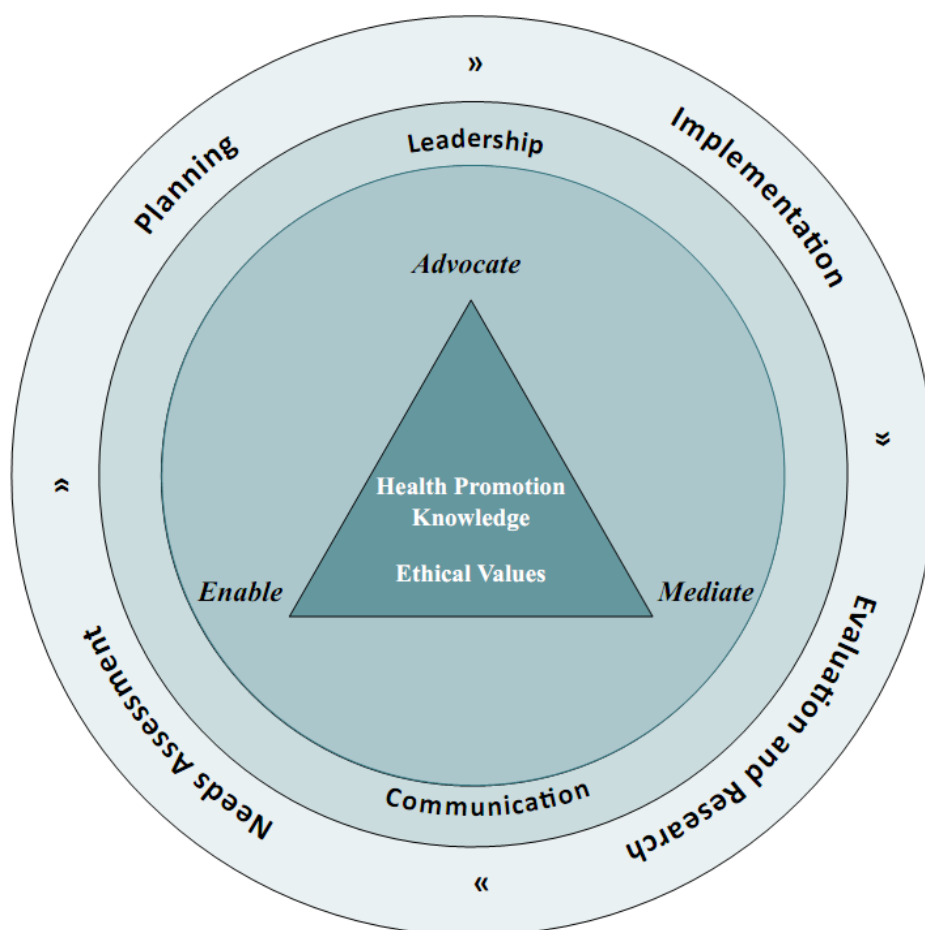


Figure3. CompHP Core Competency Framework (5, p.7)

In this framework the core competencies are defined as “a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion” (5, p.13), or in simple terms they are “what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field” (5, p.2).

The centre of the CompHP Core Competency Framework

Ethical values are at the centre of the CompHP Core Competency Framework. Health promotion principles and 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 (5, p.8)” are the base of this concept.

Health promotion knowledge stands at the centre of the framework together with the concept of ethical values showing that these two concepts underpin all health promotion action. “The core competencies require that a health promotion practitioner draws on a multidisciplinary knowledge base of the core concepts, principles, theory and research of health promotion and its application in practice” (5, p.8). All the other parts of the framework deal with health promotion practice.

The first layer of the CompHP Core Competency Framework

The first layer covering ethical values and knowledge in the CompHP Core Competency Framework shows competencies to arrange the work based on health promotion strategies stated in the Ottawa Charter for health promotion.

Enable Change “Enable individuals, groups, communities and organisations to build capacity for health promotion action to improve health and reduce health inequities” (5, p.9). A health promotion practitioner should be able to work collaboratively across sectors using health promotion approaches in order to reduce health inequities and improve health at all levels (5).

Advocate for health. “Advocate with, and on behalf, of individuals, communities and organisations to improve health and well-being and build capacity for health promotion action” (5, p.9). A health promotion practitioner should be able to raise awareness of health issues and influence key stakeholders across sectors to take action to reduce health inequities and promote health (5).

Mediate through partnerships. “Work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion action” (5, p.10). A health promotion practitioner should be able to engage partners from different sectors and facilitate development and sustainability of coalitions and networks for health promotion action (5).

The middle layer of the CompHP Core Competency Framework

Leadership and communications stand at the middle layer of the CompHP Core Competency Framework. These two domains are the main skills that a health promotion practitioner needs to have in order to deliver health promotion action.

Communication. “Communicate health promotion action effectively, using appropriate techniques and technologies for diverse audiences (5, p.10)”. A health promotion practitioner

should be able to use different communication tools and skills in a culturally appropriate manner in order to disseminate health promotion information and achieve set goals (5).

Leadership. “Contribute to the development of a shared vision and strategic direction for health promotion action (5, p.10)”. A health promotion practitioner should be able to use leadership skills like negotiation, conflict resolution, decision making and other in teamwork with stakeholders in order to improve health and reduce inequities in different levels (5).

The outer layer of the CompHP Core Competency Framework

Needs assessment, planning, implementation evaluation and research are at the outer layer of the framework, but are all connected with arrows. This means that these health promotion practices are always performed as in a circle. First step is needs assessment, second is planning followed by implementation of the plan. Next step is evaluation and research followed by needs assessment and iterating the circle constantly.

Needs 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” (5, p.11). A health promotion practitioner should be able to use different research methods and ethically appropriate approaches to the assessment of health needs (5).

Planning. A health promotion practitioner should be able to “Develop measurable health promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders” (5, p.11).

Implementation. A health promotion practitioner should be able to “implement effective and efficient, culturally sensitive, and ethical health promotion action in partnership with stakeholders” (5, p.12).

Evaluation and Research. A health promotion practitioner should be able to “use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact and effectiveness of health promotion action” (5, p.12).

3 Methodology

This chapter aims to provide an explanation of methodological choices, document and discuss taken steps that researchers in the future could learn from the challenges of this study and perform similar and improved studies in this field.

3.1 Rationale for the topic

In 2010 the National Network for Health Promotion had expressed a need for an overview of how their graduates perform in the labour market. University of Bergen has taken up this task and this master thesis is a result of it.

3.2 Rationale for choosing an exploratory approach

As mentioned earlier, there is a lack of scientific literature on the matter of how health promotion education is utilised in practice. When the issue is unknown or “no researchers had written about it” an exploratory study can be conducted (32). “A researcher may need to conduct an exploratory study in order to know enough to design and execute a second, more systematic and extensive study” (32).

3.3 Rationale for employing mixed methods

In order to answer the research question - mixed methods had to be used. Mixed methods are employed when the concern is for both what is happening and how or why it is happening the way it is (33). In this case, it is important to map current workplaces of health promotion graduates (what is happening) and how their former education is utilised through everyday tasks (how it is happening). Neither qualitative nor quantitative study alone could have answered the research question and therefore a mixed method design was appropriate for this study.

Sale et al. 2002 pointed out that multiple methods can be combined in one study if it is done for complementary purposes (34). Greene et al. identified five purposes for adopting mixed methods strategies, where one of them - *development* is used to increase validity by using results from one method to help to develop the other method (35). For example, a quantitative survey could be used to identify a purposive sample for in-depth interviews (36). This strategy of mixed method design is called sequential explanatory strategy and characterised by the collection and analysis of quantitative data in a first phase of research followed by the collection and analysis of qualitative data in a second phase (37).

3.4 Step 1- The online questionnaire

Step one in a sequential explanatory strategy is a collection and analysis of quantitative data (37). The purpose of step 1 was to map current workplaces of the health promotion graduates and to select the participants for the step 2 phase. An online questionnaire was designed to collect quantitative data. A section for commentary (qualitative data) was available in the questionnaire and was used in some cases.

3.4.1 Participants

In order to get an overview of the Norwegian health promotion workforce it was important to track as many graduates of Norwegian health promotion programs as possible. The only requirement to participants of this study was that health promotion education had to be completed in Norway. Both bachelor and master's programmes were of interest to this study. Participants were not to be bounded by their nationality or year of graduation.

The National Network for health promotion was contacted for the primary contact information of the graduates of their health promotion study programmes. They were asked to provide as many email addresses of the graduates from their institutions as possible. There

was no minimum requirement to the amount of information to provide, because the author was expecting a snowball effect. Some institutions provided a list of university emails, some personal email addresses that were filled by the students at the time of graduation.

The recruitment e-mails were sent to 290 e-mail addresses.

A consent form with a link to the online questionnaire was distributed electronically to all of the primary contacts. Participants were asked to share the link to the online questionnaire with other known former students of the field. This was done in order to trigger a snowball effect and approach as many graduates as possible.

3.4.2 Data collection

The questionnaire employed similar questions that were used in two previously mentioned workforce studies (27, 28) in order to have a possibility to compare the results. But at the same time the goal was to keep the questionnaire short and simple to increase the response rate.

Closed and open ended questions were included in a questionnaire (Appendix 2). Questions were formulated around these objectives:

- Completed education: institution, year of graduation and completed degree in health promotion. Also education that was completed before or after health promotion studies.
- Duration of unemployment after studies.
- Current job title, duration of employment, and type employment contract, as well as institution and municipality.
- Utilisation of health promotion education.
- Permission and contact details for the telephone interviews.

Time needed to fill out the questionnaire was expected to be about 5 minutes (including reading time of the consent form). Both, consent form and the questionnaire (Appendixes 2, 3) were in Norwegian.

3.4.3 Data analysis

The data collected in step 1 phase was systematically analysed using MS Excel software which is sufficient for analysis of small quantitative data sets. Also this program was chosen due to the author's experience in analysing data with this program.

3.5 Step 2 – The telephone interviews

When a sequential explanatory strategy is chosen, the step 2 phase consists of collection and analysis of qualitative data (37).

3.5.1 Participants

Participants for telephone interviews were purposely selected from 46 respondents who agreed to be contacted for the telephone interviews in the step 1 of the study. Interestingly, most of them (87%) had completed master's degree.

The aim of the selection was to get a deeper understanding of how health promotion education is utilised in different circumstances. Participants with different backgrounds, different current positions, employment type and duration were prioritised, but the main criterion was their answer about the use of education at work. In order to get a deeper understanding of the obstacles to practise health promotion in different settings the author chose to interview some participants who marked they did not use education at work as well.

The chosen participants distributed like this:

Institution of completed education		Degree of health promotion education		Year of graduation		Use of health promotion education		Previous backgrounds	
UMB	7	Master	13	2011	10	Continuously/often	11	Nursing	7
HiVe	4	Bachelor	2	2010	4	Rarely	2	Physio- or ergo therapy	2
HiGHL	2	Bachelor and master	1	2009	2	In other ways than for health promotion	2	Health promotion, psychology, teaching, health economics, social work	5
UiB	2					Not at all	1	No previous background	2
NTNU	1								
Sum	16		16		16		16		16

Table 1. Distribution of the interviewees by different criteria

19 recruitment e-mails to the first choice participants were sent in the period of 2 weeks. They were informed about the aim of interviews, anonymity issues as well as the author's language skills. An interview guide (appendix 5) that was attached to the recruitment email also included the model of competencies for health promotion (figure.2) as it was closely related to the questions. The model was not discussed with participants that did not apply health promotion education at their current workplaces.

As very few respondents replied to the invitation to participate in the interviews, a reminder letter was sent approximately two weeks after the first email. 11 new invitations were sent to the participants of the second choice.

In the meantime, some of those who only provided a phone number in the part 1 of the study and were selected for interviews received a message inviting to participate in a phone interview. All of the participants that were contacted via phone were orally informed about the aim and expected duration of the interview, and storage of their provided data, and the right to withdraw their consent at any time without any explanation and were asked for

permission to record the conversation. Both the recruitment e-mail with a consent form (appendix 4) and interviews were in Norwegian.

3.5.2 Data collection

Telephone interviews were chosen due to convenience, because the data needed to be collected from participants situated in various locations in Norway.

An interview guide with questions around these objectives was produced:

- Rationale for studying health promotion and expectations for future jobs at the time.
- Employment process, employers` perception of health promotion at the time of employment.
- Tasks and challenges of everyday work.
- Competencies for health promotion in “real life” situations.

16 interviews were conducted. All the calls were performed using Skype software due to the convenience to control the recording of the call. Interviews took from 7 to 28 minutes. All of the recordings were transcribed in the period of six weeks after the interview, and deleted.

3.5.3 Data analysis

Interviews were transcribed with as much accuracy as was possible. Interviews in *nynorsk* were transcribed to *bokmål* in order to avoid unfamiliar words during analysis. Transcribed data was grouped into themes and analysed in line with the conceptual framework.

3.6 Strength and weaknesses of the study

Employing an exploratory approach and using mixed methods carries the main strengths and weaknesses of this study. It provides wide angle, but blurred picture of how health promotion

education is utilised in current workplaces of health promotion graduates in Norway. The research question has been answered in a way that it identifies new questions for future studies.

3.6.1 Validity

Validity asks the question “do you measure what you think you measure?” (Kerlinger, 1979, p.138, cited in 38). This study had to measure how health promotion education is utilised in the job market. A mixed method approach is chosen due to the assumption that collecting diverse type of data provides best understanding of a research problem (37) and therefore allows the study to answer questions that it was supposed to answer.

More in detail validity was ensured by:

- Formulating the online questionnaire to document objective (position, type of employment contract) and subjective (to what extend respondent feels s(he) is utilising HP education at work) aspects of how health promotion education is utilised.
- Testing questionnaire and the interview guide before disseminating. It was tested both with former health promotion students from the international program and with one native Norwegian who had no previous knowledge about this study.
- Purposely selecting candidates for telephone interviews.

3.6.2 Reliability

Reliability is concerned with extend to which the study is replicable, whether another researcher with similar methodological training and understanding of the research setting can make similar observations (39). To ensure reliability of the qualitative part Yin suggests documenting as many steps of the procedures as possible (Yin RK in 37), therefore

recruitment letters, questionnaire and interview guide both in original and translated version are attached to the appendixes of this master thesis.

According to Green & Thorogood reliability refers to accuracy of reporting and consistency of coding (40). Technically transcribing interviews from tape seems to be an easy task, but according to Kvale it is not the case (38, 40). Researcher's interpretations of what they see, hear and understand cannot be separated from their own backgrounds and contexts and might influence how one transcribes data (38). In this study the author's non native background might have introduced a language bias, but all efforts to minimise it were made. All the interviews were performed in the mother language of the participants, but dialects and *nynorsk* language were translated to *bokmål* during transcription.

3.6.3 Generalisability

The recruitment emails had been sent to 290 e-mail addresses, where at least 59 were not successfully delivered to the recipients. 79 respondents have filled out the online questionnaire, which adds up to 41 % response rate. Compared to the other workforce studies (28, 29) in Norway the response rate is similar. However, the sample size in this study was smaller, and therefore generalisation of the results needs to be done with caution.

3.7 Methodological considerations and tips for future research

Gathering email addresses from universities and colleges was difficult, because this type of data is not public information. Different institutions took from few days to few months to order bureaucratic requirements and provide information needed to start this study. Also, a big part of provided email addresses belonged to university accounts. From the 59 *failure to deliver* notifications the most came with addresses of university accounts. This is probably because universities close students' accounts some period after they complete the education.

Even if students' university accounts are not closed email addresses may be checked rarely and for that reason the author would not recommend collecting this type of data as primary contact information. Instead, researchers of similar studies in the future could collect either only personal email addresses, or names of the graduates. When the names are collected their living addresses can be found via publicly available web pages, and recruitment letters can be send by post. This approach could lead to larger a sample size and therefore better significance of the results.

This approach was not used in this study because contacting via email was expected to be awarded with a better response rate. Also, since the research problem is also present between former students, a snowball effect was expected. However, it is impossible to say for sure, but most likely it was not achieved. Therefore the author of this study would recommend for the researchers of similar studies to not expect the snowball effect, and instead try to collect the contact information of as many graduates as possible.

4 Results

4.1 Step 1 – The online questionnaire

4.1.1 Gender

86% of respondents were women, 14% were men.

4.1.2 Completed education in health promotion / public health

71% of respondents had a completed master's degree and 25 % bachelor's degree in health promotion, 3 respondents (4%) had completed both bachelor and master level education in health promotion in Norway. Figure.4 shows how respondents distribute by the institution of completed health promotion education. The most of responses were received from the graduates of The Norwegian University of Life Sciences (UMB), The Vestfold University College (HIVE) and The Gjøvik University College together with the Lillehammer University College and the Hedmark University College (HIGHL).

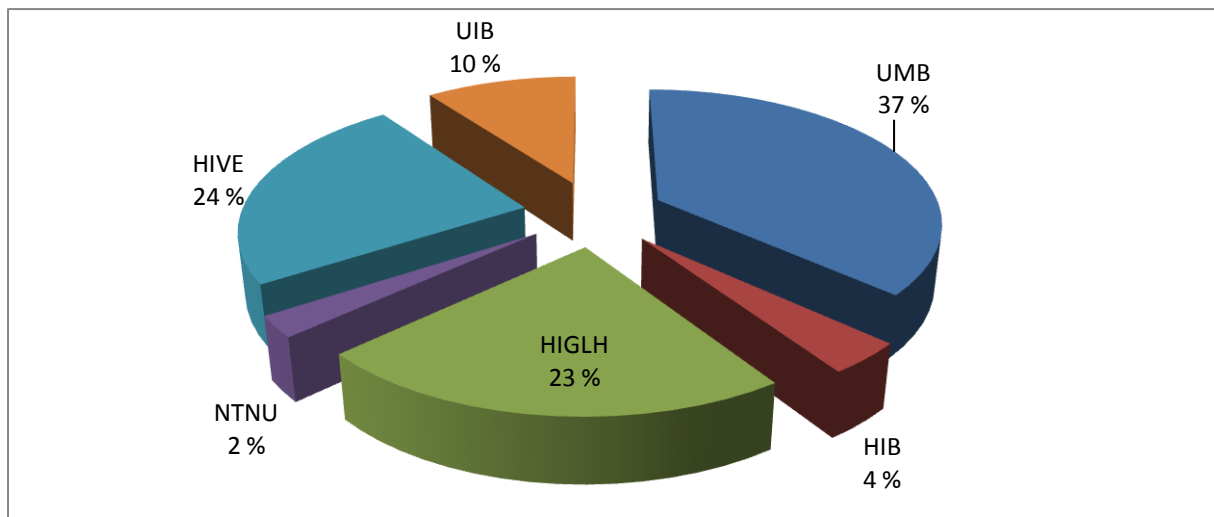


Figure.4: Distribution of the respondents by the institution of completed education

4.1.3 Year of graduation

44% of respondents received their degree in 2011, 30% in 2010, 13% in 2009, 13% in 2008 or earlier. Therefore, it would be fair to say that this study reflects only newly educated health promoters' situation in the labour market.

4.1.4 Previous education / background

Studies before health promotion (n=79)		Percents
Nursing	18	23 %
Ergo/fysio	7	9 %
Administrative background	5	6 %
Health promotion	4	5 %
Sport	4	5 %
Teaching	4	5 %
Other health	2	3 %
Radiographer	2	3 %
Nutrition	2	3 %
Language studies (one year)	2	3 %
Social work	1	1 %
Others	11	14 %
No previous education or no answer	17	22 %
SUM	79	100 %

Table 2. Education completed before studies in health promotion

Health promotion is aiming to be incorporated in all levels and sectors in the society, and therefore can be studied by persons with different backgrounds. Table 2 shows that 23 % of the respondents had a nursing background, 9% were physical- or ergo- therapists, 9% other medical backgrounds, 6% came from administrative backgrounds, 5% were teachers, 5% previously studied sport. The respondents who had some sort of medical background (highlighted in the table 2) accumulate to 41% of all respondents, and 50% of the respondents who replied to that question.

4.1.5 Workplace location

25% of respondents are currently employed in the capital, 36% in big municipalities (with more than 100 000 residents), 30 % in municipalities having between 100 000 and 10 000 residents, 7 % in municipalities having less than 10 000 residents, and 2% are abroad.

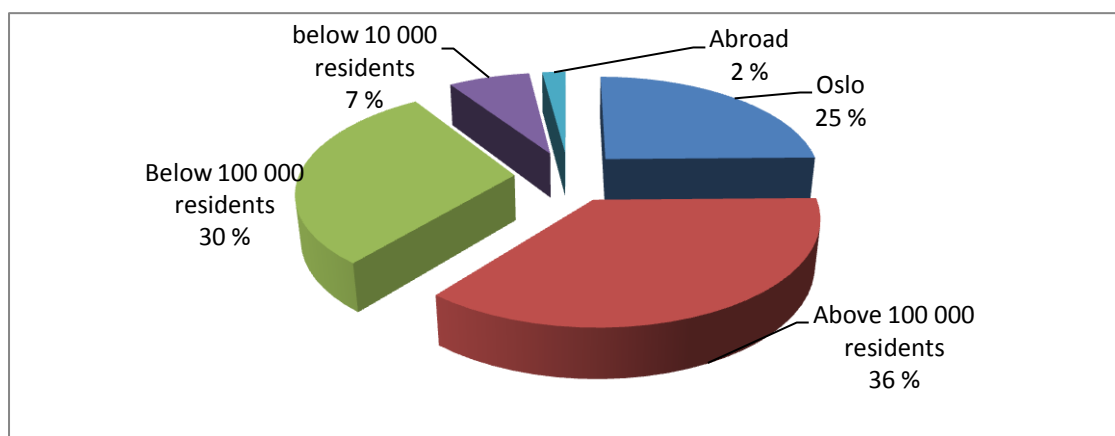


Figure.5: Distribution of the respondents by municipality's size

4.1.6 Type of employment contract

Employment contract	Respondents	Percents
Permanent, full time	26	33 %
Permanent, part time	11	14 %
PhD candidate	5	6 %
Full time, limited contract	23	29 %
Part time, limited contract	6	8 %
Full time student	1	1 %
Unemployed	2	3 %
Did not answer	5	6 %
SUM	79	100 %

Table 3: Respondents distribution by the type of employment contract

Table 3 shows that 33% have a permanent, full-time job; 14 % permanent, part time job which makes it 47 % who have a permanent job contract. 6% are currently PhD candidates; 29% have a full time job with temporary contracts; 8 % temporary part-time job; 1% are full time students, and 3% are not employed. 5 respondents (6%) did not answer the question about employment type. One respondent commented that working part time with a limited contract (in this case *on call*, Norw. *tilkallingsvikar*) was a purposeful choice for a certain period related with family situation.

4.1.7 Relevance of the current job positions of health promotion graduates

8 respondents (10%) did not answer to the question about the utilization of education in their current positions. Figure 6 shows distribution of answers only from those who answered the question (90% of respondents as 100% in this figure). 65 % of respondents replied that they utilize health promotion education continuously or often, 11% rarely, 17% said that obtained education is used in other ways then for health promotion, and only 7% are not using health promotion education at all at their current positions. This means that about two thirds of the respondents are employed at positions that are relevant to their completed education. The step 2 of this study allowed a guess that those using the education in other ways then for health promotion are using it for research.

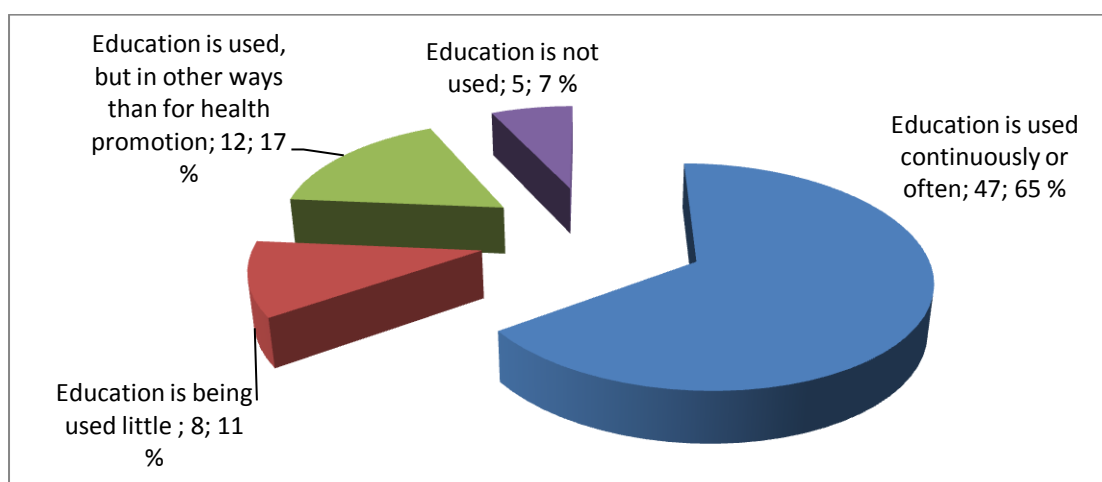


Figure.6: Respondents use of education in current jobs

4.1.8 Positions, where education is used continuously or often

Figure 7 shows how the 47 respondents who marked that health promotion education is being used continuously or often at their current jobs distributed by the job title. 28% were employed as advisors, consultants, and coordinators or similar where the employer was a municipality or the State, and 8% where the employer was an organisation or the respondent was self employed. 13% were working as lecturers or teachers at any level (from kindergarten till university/high school); 10% as nurses, with or without specialization, 15% were therapists, 11% were working as research assistants or PhD candidates. 11% did not provide an answer about their position.

Advisor, consultant and coordinator are the positions that someone with education in health promotion is expected to get after completed education (22-26). Indeed, from the 17 respondents working at these positions 81% use health promotion education often or continuously, and three 14% have little possibilities for it or use education for other purposes than health promotion, and one did not answer the question.

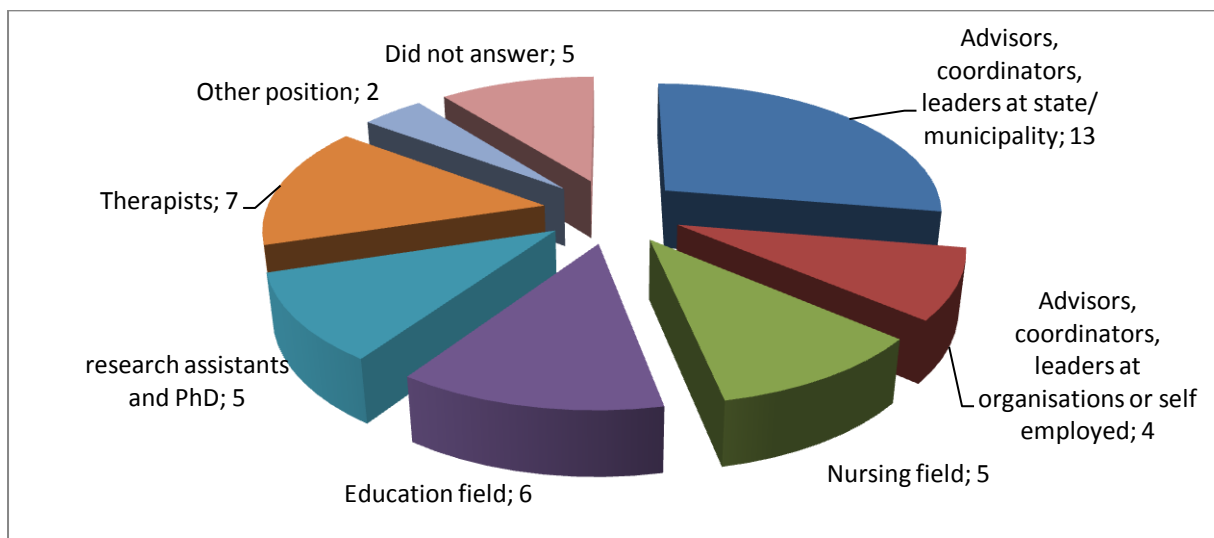


Figure.7: Positions where health promotion education is utilised the most

Moreover, in two of these positions bachelors in health promotion were employed, but it is worth noting that they were employed at municipalities with less than 30000 residents.

Further on, most of these positions were full time, but only half of them were with permanent contracts (Figure 8).

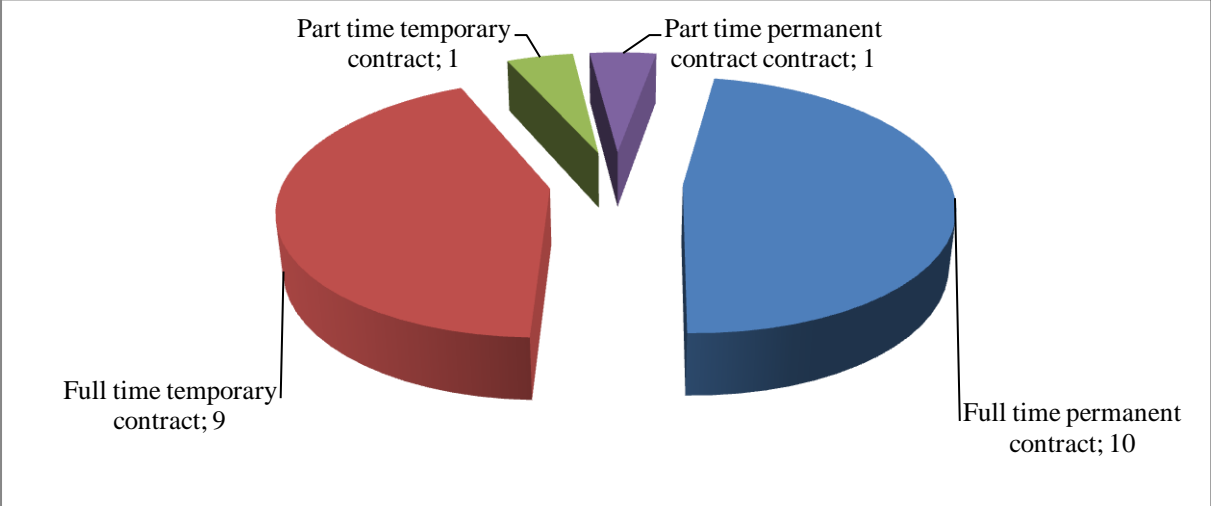


Figure 8 Advisor, coordinator, leader or consultant position distribution by employment contract

In comparison, those working in the medical field (nurses, physiotherapists, social workers) are more likely to have a stable workplace (Figure 9). Two thirds of health promotion graduates working in the medical field have a full time permanent job. Stable income might be one of the reasons for health promotion specialists to come back to the “old” field.

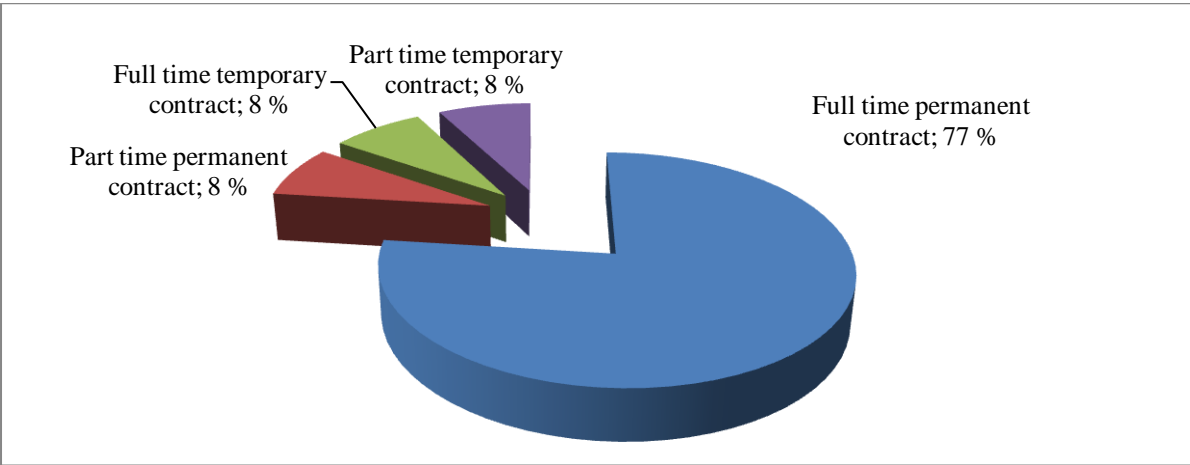
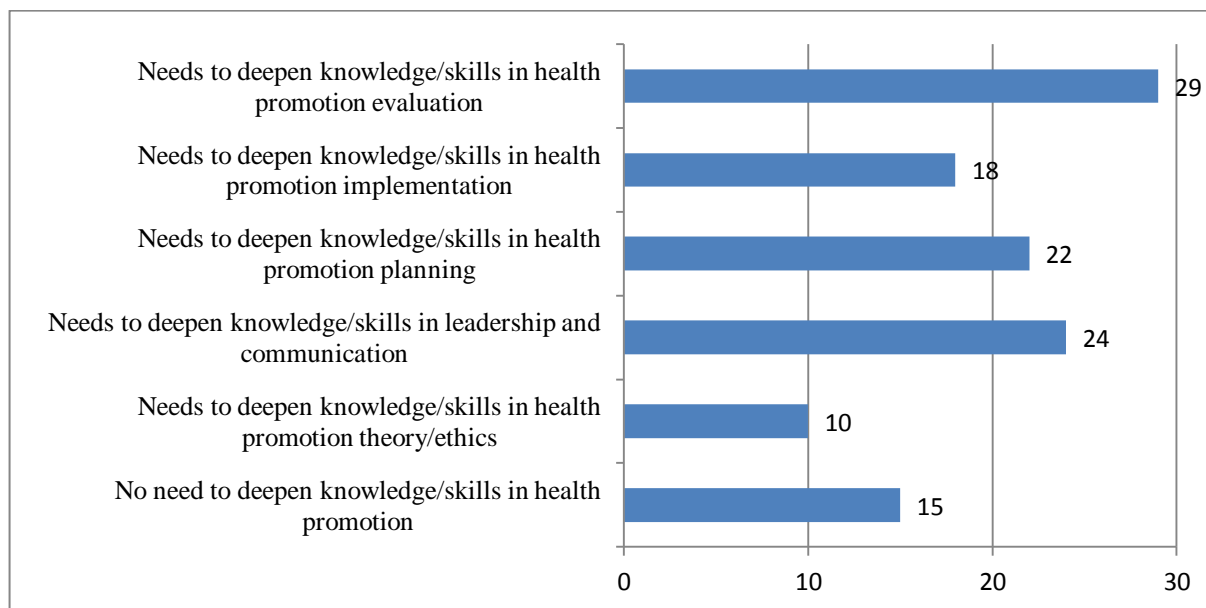


Figure 9 Distribution of respondents employed in the medical field by the type of employment contract.

4.1.9 Need to deepen knowledge and skills in health promotion



*Figure 10. Need to deepen knowledge and skills in health promotion
(Multiple choice available)*

19 % of respondents did not reply to the question if they need to deepen their knowledge/skills in health promotion, and the same many replied that they do not need to deepen knowledge/skills in health promotion in any of the given domains. This means that 62% of all the respondents feel they need to deepen their knowledge in at least one of the health promotion competency domains. Figure 10 shows which health promotion competencies domains are most needed to deepen knowledge/skills in by health promoters in practice. The domains related to practice were two to three times more often marked in comparison to the health promotion theory and ethics domain. Compared to a previously described Australian study where 89 % of health promotion specialists had need for continuous education (15), health promoters in Norway have lower needs to deepen knowledge/skills even if only respondents who replied the question are taken into account. The ones stating no need to deepen education in health promotion had shown no pattern in means of background, completed university or use of education at work. There would be need

to investigate further what the reasons for the need to deepen knowledge are. Do the practitioners feel there were gaps in education programs that should be addressed? Or are health promoters just always “hungry” to know more? This question was inspired by the two respondents who commented on the question about the need to deepen knowledge:

“The more I know, the more I know that I don’t know. The need to deepen/improve knowledge is always there and depends on working tasks and politics of that time”

“I always feel the need to learn”

The questionnaire allowed providing a field they need to deepen knowledge/skills in. Ten respondents used this opportunity and reported they lack knowledge in strategic work, municipalities systems, project leadership, and nutrition. One mentioned the need to know more about health promotion at individual level. Three needed to know more in quantitative research methods and statistics.

4.1.10 Comparison with other studies

Compared to the results of other workforce studies in Norway fewer graduates of health promotion programs get permanent and full time jobs. However, as mentioned before, this study can not compete with the others due to the small sample size, but the tendency is there. Some factors that might be influencing this tendency are discussed later in the result section (see 4.2).

Report of:	Relevant job	Permanent job	Full time job	Unemployed	Ref.nr.
UiB, HiB, NHH	60%	94%	-	2%	28
UiT	-	56%	87%	-	41
UMB	87%	70%	92%	2%	29
This study	65%	47%	62%	3%	-

Table 4: Comparison of employment profile with other workforce studies in Norway

4.2 Step 2 – the telephone interviews

The goal of step 2 was to explore what it means to be a health promoter in Norway. This report will cover aspects of how health promotion education and work is perceived by the graduates and their employers, and what influences possibilities to apply health promotion education in different settings?

4.2.1 Motivation to study health promotion

Applicants have various backgrounds when they enter different programs of health promotion education. Interviews showed that many students did not know for sure what education they enter to and what positions they can apply to after graduation.

“It just looked interesting. I thought it would be more... practical in a way, nutrition or physical activity or similar. But I think it was interesting too”

“First of all I thought it was exciting” “I didn’t think much about it (red. Work possibilities after education)”

“...from interest for health and nutrition.” “I wanted to work at a municipality’s or State’s project”

These were the views expressed by bachelor students. Most of master interviewees entered the program because they wished to change their positions, but also had no specific expectations for work.

“I had no special career wishes, just wanted to have more possibilities and not only for work in health sector”

“I wanted not to continue working where I worked before, but I had no special expectations or special type of work”

The second biggest group of interviewees (25% of all interviews) took their masters education more for a degree than for competence in health promotion.

“My goal was to take a master and try to go out of that I had been working before”

“It was not health promotion that was important, but a master degree and research competence” - A nurse, working at a hospital

“I was interested to learn about research and had a project at work”

“I was interested in working with projects, but it is difficult to get support from the hospital, so I wanted to get better competence”

However, there was one case where the interviewee wished to get better competence in the current work because health promotion was relevant.

“I was not interested in changing the job. I wanted to use it in my current work” - Teacher

All the interviewees seemed to be satisfied with the gained education, but some also shared ideas of how it could be improved.

“It could have been good to learn more tools that could be used a little more concrete in a work life.<...>I am satisfied with the studies, I think it was exciting. I would like to use it a bit more everyday, but maybe I get to do that later”.

“Yes there could have been more focus on that”- interviewee that marked s(he) has a need to deepen knowledge in project leadership. In the future s(he) wishes to apply for / lead projects at the current workplace.

One respondent of the study shared his/her concern regarding the education in the comment section of the step 1.

“I feel that this kind of theoretical education led to relatively few employment opportunities, and this was a common opinion among my fellow students. Relevant jobs employers often seek someone with practical training in the base (such as nurses), or people with other qualifications (engineers). Personally I feel that I was lucky to come through the eye of the needle, but it was worse for many others.”

The current situation of what it means to be a health promotion graduate in Norway can be well reflected with these citations:

“Everyone after this education have to define for themselves who they are and what they can do”

“Everyone with health promotion education has a task to represent what health promotion really is”

“While I studied, I asked my colleagues “What do you think is health promoting in this department?” It was my way to understand what health promotion is, it is not easy to understand what it is” – Midwife.

“People often misunderstand what health promotion is, they think it is a pure medical discipline, traditional medicine discipline. <...> they think I have some kind of medical background when I actually don't.” – Teacher.

That *“people often misunderstand what health promotion is”* might be caused by a lack of professional standards, but also by the backgrounds of the candidates that apply to study this field. In this study almost half of all candidates had a medical background. This might form a public opinion that health promotion is a part of the medical field. Further studies could investigate how institutions responsible for health promotion education prioritise the variety of backgrounds during the admissions? When health promotion is seeking to be included in all levels and sectors in the society, further investigation of this question seems to be relevant.

It is important to note that some interviewees with master degree perceived themselves more by the previous backgrounds and not as health promoters.

“I just have to say that I am not working with health promotion”

The interviewee meant that s(he) did not change work after studies and therefore wanted to make sure that it is not a misunderstanding that s(he) was chosen for an interview in the study of health promotion workforce.

4.2.2 Employers' perceptions towards health promotion graduates

Several interviewees told they needed to explain their competencies and capabilities to their future employer during job interview.

“I wished I had a title” – Research assistant.

One interviewee expressed a concern that when the education is not known to the job market - it creates difficulties even to come to an interview. Especially if applying to positions that are popular and the motivation letter needs to be short and clear.

“You can not write a book about what your competencies are”

Interviewees were asked what they think about accreditation of the health promotion education. While two did not have a strong opinion, the majority were positive. However, they didn't seem to know about this attempt and only one of them had seen the model of health promotion competencies before the interview. One interviewee that was positive to accreditation expressed a concern of how it would work in practice.

“I am very positive to it, but I mean only if universities are smarter to distribute it further to job market. So they should not make a document<...> if no one would use it actively”

One bachelor interviewee decided to continue studying immediately after completing the degree to have better job opportunities. S(he) stated that there were very few possibilities to get a relevant job. Now the interviewee is studying in a state financed education, where students are seen as employees, they get a salary throughout the study and the year of the obligatory practice.

Other challenges to coming into the labour market seemed to be lack of practical knowledge and/or work practice in general. The two citations below are taken from the comment section in the online questionnaire.

“The relevant jobs get those ones who have more work experience or are physiotherapists” – Bachelor working in a small municipality (less than 10 000 residents) for two years at a job position that requires no qualification.

“I applied for a number of positions that were relevant to the studies but was rejected due to lack of experience”. – Respondent with bachelor and master’s degree in health promotion, living in a big municipality.

Further on the respondent wrote that s(he) is now working to build up more work experience (is working with various administrative tasks, monitoring of projects in a field that has nothing to do with health promotion) before starting a new round of applying for relevant jobs. It is interesting to note that this respondent is working in a municipality with more than 100 000 residents, while the previous respondent -in a much smaller one. This shows that possibilities to get a relevant job not always depend on the size of municipality.

Municipalities are different with different perceptions of health promotion.

“In the municipality where I work they have no interest for employees with health promotion education- but they bought a package long time health (Red.: Norw. langtidsfrisk) from Johnny Johnsson¹” – Teacher

The citation above is taken from the comment section in the online questionnaire.

Unfortunately, this respondent did not participate in a phone interview, so it was not possible to analyse the situation more. From the citation we could only stipulate that a new position or an additional task the person got might have been influenced by the new Public Health Act. One interviewee specifically mentioned that his/her job position was related with the newly released Acts.

“They were looking for someone with a competence to work with The Coordination reform”- Advisor working in Oslo

In a few cases graduates of health promotion programs got their jobs due to the combination of the previous and the last education. The citation below is an example of how a health promotion graduate got a leader's position, showing that some stakeholder's recognise education in health promotion as providing competence in leadership.

“It was a combination, because an important criterion is to be a nurse in this type of job, and a master's degree. It could have been a master in work organisation and leadership, but it was absolutely positive with a master in public health too” – Department leader at a nursing home

However, it's not all leaders that find health promotion education as resourceful.

“The employer does not see that as a resource, no” – midwife working in a health promoting hospital.

¹ The purpose of the “*langtidsfrisk*” is to provide tools to businesses and organizations to create effective and profitable jobs that provide good conditions so that employees are involved and responsible and are experiencing job satisfaction and contribute to organizational goals (42).

“I got the job because of my previous experience. It had actually no meaning that I took a master” – Previously a social worker

4.2.3 Health promotion in different settings

Health promotion is a multidisciplinary field and can be applied to different settings.

“I am using strategies from health promotion in the teaching process”, “That to experience mastering is basic for good learning. I am working towards that every single pupil experiences mastering” “I was always concerned how to have good relationship with pupils, but it [red. education in promotion] gave me even better understanding of how important it is”. - Teacher

“It is a project were we recruited users that are single or have little network, or and have psychological diseases, to come together for a walking tour once a week <...> it is very health promoting, because there is a lot of physical activities to go a tour and hopefully it reduces loneliness.” – Therapist working fulltime with projects.

Interviews showed that even in similar settings possibilities to apply health promoting work might be different. In one case where the interviewee was involved in a health promotion project in a hospital s(he) even decided to take up master studies in health promotion to “learn more about research”. Now s(he) is working with the same project and is able to employ empowerment strategies to her work.

“We use empowerment. It is important that the parents and not we as hospital staff are the ones who have the control over children” – Nurse, at a newborn department.

While in another similar setting - newborn department in a hospital – the interviewee felt s(he) had little possibilities to do health promotion/use the education at work. Further on the

interviewee mentions that the employer institution belongs to a network of health promoting hospitals.

*“The employer does not see that as a resource, no. That is sad. <...>
My hospital belongs to health promotion hospitals, so I find it being
just nice words” – Midwife*

A similar case of a community nurse working at home care showed that health promotion education can be possible, but difficult to apply where work descriptions and given tasks are not flexible.

*“Only employment percentage changed after studies. Formally tasks
haven’t changed, I do things differently, but that is my own initiative”
– Community nurse*

In this case working health promoting meant putting extra effort, trying to see resource and positive health and incorporate it to standard homecare routines. It also created a “*dilemma between given tasks that are not so relevant*” for this interviewee.

The extend to which health promotion graduates are able to apply their education to work are strongly related with how their education is perceived by the leaders in the workplace institution. In one case, a teacher working in a health promoting school has been involved in health promotion projects together with the rector.

*“We were together in that development work <...> she sees a
meaning in it, but it is not all leaders that do that.” Teacher.*

Later on the interviewee expressed concern about the future work, because this year’s rector will change in autumn:

*“It will be exciting to see how the new leader thinks”. “They know
very differently, the different leaders” - Teacher*

One graduate of a bachelor program in health promotion is currently working at a small municipality as a public health coordinator in a newly established position and therefore has a freedom of the tasks.

“Do that what you think is good. That is what I was told. And it was very nice” - Bachelor in health promotion

The public health coordinators' tasks from the beginning were establishing and maintaining a healthy life centre (Norw. frisklivscentral). Later on, s(he) became a leader for the municipality's part for sports culture and a coordinator for the school project aiming against drugs and alcohol use among youth. Other tasks were arranging information posters with descriptions of hiking tours in the municipality. For this interviewee the flexibility at work, freedom and a variety of the tasks were the factors that gave the most meaning to the job. These factors together with high responsibility and good working environments led to thriving at work for several other interviewees.

In one case opposite circumstances lead to leaving a position (as health, environment, safety (Norw. HMS) and quality coordinator) which required health promotion education and coming back to the previous field of work which required no health promotion knowledge.

“It was too little to do, a bit too little inspiring and exciting, few possibilities to make changes”

There were cases where interviewees worked with data in the office but saw it as health promoting work.

“Pure office work” – therapist working at a disease registry centre

“I make the data ready for analysis” –PhD student at a university

While the actual working tasks were office related, interviewees felt that seeing the whole picture of being a part of a health promotion research project gives a feeling of relevance to the job.

4.2.4 Challenges at work

Issues related with practical tools of project management and municipalities systems came up when interviewees were asked to tell about challenges at work:

“The challenge is to be new, to find out things by myself, to work in frames and requirements that I am not familiar with.” – Department leader in a hospital.

“I am not placed in the municipality’s administration. I have to go through many leaders before I get to do something...concrete” - Public health coordinator.

“Concretely, it is to apply for projects” –Therapist, continuously working with projects.

The new Professional Standards for health promotion Handbook addresses these issues and notes that a health promoter needs to have knowledge in:

- Principles of project/programme management
- Principles of effective human and financial resource management including performance management and risk management
- Theory and practice of programme implementation (21)

While the standards are very demanding and might be impossible to fully implement in health promotion programs, some practical issues should have more focus in the tutorial of the future programmes. That could lead to better utilisation of the theoretical part of the education and therefore better health promotion practice.

4.3 Other remarks

It has been rewarding to perform a study that was needed not only for the National Network for Health Promotion but also many graduates of health promotion programs. In the comment section of the online questionnaire some students wished “*Good luck!*” and expressed their interest in the topic: “*Exciting project that will be interesting to follow up!*”. The possibility for follow up (receive the main results of this study) was offered as motivation to fulfil the questionnaire. 84% of the respondents used this option showing high interest in the topic. The same impression was felt throughout the interviews too.

4.4 Summary of the main results

This chapter aims to summarise the main results of both steps of this study. It is not an easy task because every case seems to be so different. Beginning with the motivation to study health promotion the answers were often alike, but they could roughly be grouped into two main groups. The biggest one was to take an education for its values and interestingness, and the other group which was only common between master students, wanted to take an education to strengthen their competence in research. No one studied health promotion for the field’s good perspectives for career possibilities as the author of this study has expected. Generally students were satisfied with their studies, but some wished that the education had provided them with more practical tools. At the same time the most of the interviewees expressed high needs for standards for the education and clearness of their competencies.

After completed education the health promoters found themselves in a wide range of situations. The author of this study expected to find a pattern related to the size of municipalities, but similar challenges were present in different municipalities. Some graduates got a relevant job in the capital; some were employed at very small municipalities, while

others found the job search difficult. 97 % of the respondents in this study had a job at the time of the study. 65 % of respondents marked that they continuously or often use health promotion education at work. The positions where those graduates were employed varied: advisors, public health coordinators, teachers, nurses and therapists. However, other respondents marked they have few or no possibilities to practice health promotion even if their positions were the same or similar to those mentioned above. The stakeholders (employers) had different perspectives on how resourceful health promoters can be to the workplace and this seemed to be the main influencing factor to what extent health promotion graduates can use their education at work.

Public health coordinators, advisors, leaders and other similar positions are the ones where health promotion education is utilised the most- four of five respondents working at these positions marked that they use the education continuously or often. However, only half (59%) of them had a permanent job contract.

There is a hope for more relevant positions to appear at the municipality level in the near future due to the new Public Health Act. Unfortunately, this study only discovered one case directly related to the recent changes in the law. There was also one case of a newly established public health coordinator position that was probably influenced by at that time upcoming changes, but it was not specified during the interview. It would be interesting to map the influence of the new law to the health promotion workforce, but yet, it was not an aim this study.

5 Discussion

This chapter aims to discuss the previous findings through an angle of the conceptual framework. As this study explores what it means to be a health promoter in Norway and how health promotion education is utilised in practice, a model of health promotion competencies has been a great tool to guide this research. The standards for health promotion have not been included in the design of this study because it was published after the biggest part of this research was conducted. Yet, due to high relevance to the competency framework – standards for health promotion will be included in this section.

5.1 Health promotion theory and the ethical values

Health promotion theory and ethical values is the core of all health promotion competencies. “The core competencies require that a health promotion practitioner draws on a multidisciplinary knowledge base of the core concepts, principles, theory and research of health promotion and its application in practice” (5, p.8). Interestingly, the need to deepen the knowledge in this field was lowest compared to the other ones in the framework. All the other competencies in the framework are related with practice and were marked two to three times more often as a needed to deepen knowledge in theory and ethics. This finding is in line with previously described interviewees concerns about education that lack of practical tools are related to the challenges they experience at work.

5.2 Health promotion principles: Enable, Mediate, Advocate

The work principles were not included in the Step 1 of the study because it requires time to reflect on ones work and therefore not appropriate in a quantitative part of the study. In the Step 2 interviewees were not asked directly which health promotion principals they employ the most in their practice, but it came clear through descriptions of a usual workday.

Results showed that the most commonly employed health promotion principle was *enabling change* through empowering and building personal skills at individual and group levels in different settings. Each health promoter had their own way to “enable individuals, groups, communities and organisations to build capacity for health promotion action to improve health and reduce health inequities (5, p.9)”, depending on their workplaces and their titles. A focus on individuals came repeatedly throughout the majority of the interviews. While at the same time to “advocate with, and on behalf, of individuals, communities and organisations to improve health and well-being and build capacity for health promotion action” (5, p.9) and “work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion action” repeatedly seemed to be challenging. For an effective application of health promotion education, a basic knowledge of State and municipal structures should be added in the study curriculum of the programs where it is not included yet. Especially now, when the new laws in Norway are effective and more positions to ensure health promotion action are expected to be placed in municipalities. Also if the standards for health promotion would be implemented- a health promotion specialists would be required to have knowledge in the systems, structures and functions of different sectors, organisations and agencies (21).

5.3 Personal skills: Leadership and communication

As described in HP competencies handbook, a health promotion practitioner should be able to use leadership skills like negotiation, conflict resolution and decision making in teamwork with stakeholders in order to improve health and reduce inequities in different levels (5). However, as discussed earlier, a lot depends on the stakeholders of the institution where the interviewees work. When stakeholders were not in one team with the health promoters and did not see them as recourse, there was little that one could do.

A health promotion practitioner should be able to use different communication tools and skills in order to disseminate health promotion information and achieve set goals (5). While many interviewees mentioned that communication skills are important at their jobs, it was mainly understood as verbal communication face to face or via telephone. Employing media to disseminate health promotion information was very rarely mentioned in the interviews. In two cases interviewees mentioned making handouts and booklets or posters of available tours in the local area. One was employed as public health coordinator, another as advisor. It seems that in the positions that are most relevant to health promotion communication skills are better utilised. Another case of disseminating health promotion education was when the interviewee presented her master thesis from health promotion studies to her colleagues at work. However, it does not mean that other health promoters do not use various tools to disseminate health promotion information; it might have been not mentioned because it takes a small part of daily tasks. Communication is a tool to achieve health promotion goals, and this study focused more on regular tasks at work and due to the methodological approach could not investigate the variation of used tools in detail.

5.4 Needs assessment, planning, implementation evaluation and research

Needs assessment, planning, implementation evaluation and research are supposed to be performed continuously as a routine (5). However this pattern was not evident in this study, not even in the positions that are considered the most relevant to health promotion education. The interviewees were working the most with implementing health promotion activities (projects). One case included planning and implementing as a constant work routine. Another case where the interviewee was working with one project s(he) had performed an evaluation study.

Accreditation of health promotion education

The health promotion competency framework was developed as a part of the intent to standardise health promotion education in Europe and implement an accreditation system. Meanings on accreditation of the health promotion varied from highly desired to neutral between interviewees. Negative opinions were not present on this matter. This finding is in line with research done by CompHP projects' work package 8 where they found overall support for implementation of an accreditation system for health promotion (3).

6 Conclusions

The study's purpose to explore how health promotion education is utilised at the current workplaces has been reached at the intended level. The results provide not a detailed, but a wide angled picture and identify issues for future research.

Purely in numbers, the employment rate of the graduates with health promotion education was about as high as graduates of other programs in Norway - 97 %. In terms of relevant job, only 65% could say that they do health promotion/use health promotion education at their current workplaces.

Public health coordinator, advisor, leader and other similar positions are the ones where health promotion education is utilised the most- four of five respondents working at these positions marked that they use the education continuously or often. However, only half (59%) of them had a permanent job contract.

Other positions where health promotion graduates could utilise their education were: teachers, nurses, therapists and etc. But at these positions not everybody had possibilities to utilise their health promotion education. The main influencing factor to what extend health promotion graduates can use their education at work seemed to be the stakeholders (leaders and employers).

The most challenging tasks at the current workplaces of health promoters were mostly related with project management and other administrative tasks. Also the competency domains related with practice were marked as needed to deepen knowledge two to three times more often than health promotion theory and ethics domain.

The interviews revealed high demand for the standards for health promotion education and wider spread of the competencies that it provides to the society. There is a need for better communication between institutions providing health promotion education and the job market.

6.1 Implications for practice

- The challenges that health promotion graduates experience at work seem to be related with lack of practical knowledge in project management and work organisation. While these issues are included in the professional standards for health promotion, the institutions offering health promotion programs should consider strengthening the focus on those issues in their study curriculum.
- The stakeholders (leaders, employers) had different perspectives on how resourceful health promoters can be and this seemed to be the main influencing factor to what extent health promotion graduates can utilise their education at work. Municipalities together with the universities responsible for health promotion education should better communicate health promoters' competencies to leaders in different settings as this may trigger creation of better possibilities for health promotion practice.
- According to the results, an accreditation of the health promotion education might help to better represent health promotion field both in job market and the society and would be highly appreciated in the workforce.
- Almost half of the respondents have a background in the medical field. It may be causing misperception of the field in the society and difficulties to implement health promotion in all sectors.

6.2 Implications for future research

- While the response rate was 41% - about as high as was achieved by similar workforce studies in Norway - the sample size achieved through collecting email addresses from different universities was too small to draw significant conclusions. Researchers performing similar studies would therefore be advised to collect lists of graduates' names and gather further contact information by post or phone.
- While leaders' role seems to be crucial to how health promoters are able to apply their education in practice, and further investigation of this issue is needed. Study comparing leaders' perception of health promotion graduates could be conducted in order to improve the understanding and raise the level of health promotion education utilisation in practice.

6.3 Other remarks

Hopefully, the results of this study will be published in ISECN (IUHPE Student and Early Career Network) or/and IUHPE newsletters and help other researchers to learn from the challenges of this exploratory study and deliver similar and improved studies elsewhere in Europe.

For any inquiries related to this study please contact the author during office hours by phone or e-mail found in the attachments. The author of this study would be happy to answer the questions and/or contribute to future research in this field.

References

1. IUHPE: Capacity building, Education & Training. Accessed 19.03.2011, Available from URL: <http://www.iuhpe.org/?page=52&lang=en>
2. Dempsey, C., Barry, M.M. & Battel-Kirk, B. (2011) Report Developing a European consensus on Core Competencies for Health Promotion. International Union of Health Promotion and Education (IUHPE). Available from URL: http://www.iuhpe.org/uploaded/European_Consensus_on_Core_Competencies_for_HP.pdf
3. Gallardo, C., Martinez, A., Zaagsma, M., García de Sola, S. and the CompHP Project Partners (2012). Testing the implementation of the CompHP Pan European Accreditation Framework in Practice Settings. IUHPE. Paris
4. Ellery J. Training the public health education workforce. *Am J Public Health*. 2002;92:1053.
5. Dempsey, C., Battel-Kirk, B. & Barry, M.M. (2011) The CompHP Core Competencies Framework for Health Promotion Handbook. Paris: International Union of Health Promotion and Education (IUHPE).
6. Mittelmark MB, Wise M, Nam EW, Santos-Burgoa C, Fosse E, Saan H, Hagard S, Tang KC. Mapping national capacity to engage in health promotion: Overview of issues and approaches *Health Promot. Int.* (2006) 21 (suppl 1): 91-98.
7. The Ministry of Health and Care Services, Meld.St 16- Nasjonal helse- og omsorgsplan (2011–2015), Accessed 12.03.2012 Available from URL: <http://www.regjeringen.no/pages/16251882/PDFS/STM201020110016000DDDPDFS.pdf>
8. Barry MM, Allegrante JP, Lamarre MC, Auld ME, Taub A. The Galway Consensus Conference: international collaboration on the development of core competencies for health promotion and health education. *Glob Health Promot.* 2009;16(2):5–11
9. Mittelmark MB, Fosse E, Jones C, Davies M, Davies JK. Mapping European capacity to engage in health promotion at the national level: HP-Source. *net. Promotion & education.* 2005;12(1 suppl):33.
10. Barry M. Capacity building for the future of health promotion. *Global Health Promotion* December 2008 vol. 15 no. 4 56-58. Accessed 12.03.2011, Available from URL: <http://ped.sagepub.com/content/15/4/56.full.pdf+html>
11. Contu, P. and Sotgiu, A. and the CompHP Partners (2012). Mapping competencies against academic curricula and exploring accreditation of educational and training programmes. IUHPE, Paris http://www.iuhpe.org/uploaded/CompHP/CompHp_Mapping_in_Academic_Settings.pdf
12. König C, Mittelmark M. Higher education in health promotion in Europe: a comparative analysis of master's level training programmes using HP-Source.net. *Promot Educ.* 2008; 15: 30–35
13. Battel-Kirk, B. and Barry, M.M. (2011) Scoping Study Health Promotion Workforce Capacity and Education and Training Needs in Low and Middle Income Countries. International Union of Health Promotion and Education (IUHPE), Paris.
14. Allegrante JP, Moon RW, Auld ME, Gebbie KM. Continuing-education needs of the currently employed public health education workforce. *Am J Public Health*. 2001;91:1230–1234
15. Swerissen H, Tilgner L. A workforce survey of health promotion education and training needs in the state of Victoria. *Aust N Z J Public Health*. 2000;24:407–412.
16. Fleming M, Gould T: Educating the public health workforce: issues and challenges. *Aust N Z Health Policy* 2008, 6(8):1-8.
17. Baumgarten K., Ergebnisse von Absolventenverbleibstudien im Studienbereich Gesundheitsförderung und management der Hochschule Magdeburg-Stendal, Berlin, 2011. Accessed 16.09.2011 Available from URL: http://www.gesundheitberlin.de/download/Baumgarten,_Kerstin_Studierendenforum_11-02-28.pdf
18. International Union for Health Promotion and Education (IUHPE) An official webpage. Accessed 24.01.2012, Available from URL: <http://www.iuhpe.org/?page=614&lang=en>
19. IUHPE Constitution. Ratified by the IUHPE General Assembly on June 14, 2007. Vancouver Convention and Exhibition Center, B.C., Canada. Accessed 24.01.2012, Available from URL:

- http://iuhpe.org/uploaded/About%20us/Constitution%20_Bye%20Laws/CONSTITUTION2007.pdf
20. HP.Source.net official webpage. (The Comprehensive Database of Health Promotion Policies Infrastructures and Practices). Accessed 02.04.2011 Available from URL: <http://www.hp-source.net>
 21. Speller, V., Parish, R., Davison, H., Zilnyk, A., and the CompHP Project Partners (2012). The CompHP Professional Standards for Health Promotion Handbook, IUHPE, Paris
 22. University of Bergen official webpage. Accessed 04.04.2012, Available from URL: <http://www.uib.no/ledelsen/sentrale-utvalg/styrer-og-utvalg-paa-fakultets-og-instituttnivaa/styrer-og-utvalg-ved-det-psykologiske-fakultet/programutvalgene/programutvalget-for-helsefremmende-arbeid>
 23. Vestfold University Collage official webpage. Accessed 04.04.2012, Available from URL: <http://www.hive.no/studietilbud/helsefag/master-i-helsefremmende-arbeid/>
 24. Gjøvik University Collage official webpage. Accessed 04.04.2012, Available from URL: <http://www.hig.no/nyheter/arkiv/mhpc>
 25. Norwegian University of Science and Technology official webpage. Accessed 04.04.2012, Available from URL: <http://www.rchpr.org/about/backgroundandvision.aspx>
 26. Norwegian University of life Sciences. Master in Public Health: Program description. Accessed 04.04.2012 Available from URL: http://www.uhr.no/documents/Master_i_folkehelsevitenskap___samarbeid_mellom_UMB_og_HiO.pdf
 27. Bergen University Collage official webpage. Accessed 04.04.2012, Available from URL: <http://www.hib.no/studier/studie.asp?studieID=FHA>
 28. Karrieresenteret i Bergen. Fra studier til job I Bergenregionen- Kandidatundersøkelse 2011. Accessed 02.11.2011, Available from URL: <http://www.sib.no/no/karriere/pa-terskelen-til-arbeidslivet/kandidatundersokelsen-1/kandidatundersokelsen-2011/view>
 29. Universitetet for miljø- og biovitenskap. Kandidatundersøkelse UMB : Kandidater uteksaminert i perioden 2005-2009 Accessed 02.11.2011 Available from URL: http://www.umb.no/statisk/forsiden/Kandidatundersokelse_2010.pdf
 30. Ministry of Health and Care Services, A short presentation of the New Public Health Act: http://www.regjeringen.no/upload/HOD/Hoeringer%20FHA_FOS/1234.pdf
 31. Lov om folkehelsearbeid (folkehelseloven). Available from URL: www.helsedirektoratet.no
 32. Neumann, W.L. (2007). Basics of social research: Qualitative and quantitative approaches. (2nd ed.). Boston: Allyn and Bacon
 33. Sosulski, M., & Lawrence, C. (2008). Mixing methods for full-strength results: Two welfare studies. *Journal of Mixed Methods Research*, 2(2), 121-148.
 34. Sale, J. E. M., Lohfeld L. Brazil K. Revisiting the Quantitative-Qualitative Debate: Implications for Mixed Methods Research. *Quality and Quantity*, 36, (2002).
 35. Greene, J. C., Caracelli, V. J., & Graham, W. F. (1989) "Toward a Conceptual Framework for Mixed-method Evaluation Designs". *Educational Evaluation and Policy Analysis*, Vol 11, No. 3, pp 255-274.
 36. Rocco, T., Bliss, L., Gallagher, S. and Perez-Prado, A. 2003 'Mixed methods research in organisational systems', *Information Technology, Learning and Performance Journal* 21, 1: 19-40.
 37. Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches*. (3rd ed.) Thousand Oaks, Calif: Sage Publications
 38. Kvale S, *Det kvalitative forskningsintervju / oversatt av Tone M. Anderssen og Johan Rygge*. Ad notam Gyldendal, 1997
 39. Stebbins RA, *Exploratory research in the social sciences*, Sage Publications, California: 2001
 40. Green J & Thorogood N. *Qualitative Methods for Health Research*. SAGE, London, 2004.
 41. Kandidatundersøkelsen 2012 for Universitet i Tromsø. Accessed 04.04.2012 Available from URL: http://uit.no/Content/301463/Kandidatunders%C3%B8kelsen2012_ferdig.pdf
 42. Møtsted Langtidsfrisk official webpage Available from URL: http://www.langtidsfrisk.se/no/visionen_n/

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Appendix 1 Ethical approval from the Norwegian Social Science Data Services

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES



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Vår dato: 21.11.2011

Vår ref: 28380 / 3 / SSA

Deres dato:

Deres ref:

KVITTERING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 10.10.2011. All nødvendig informasjon om prosjektet forelå i sin helhet 18.11.2011. Meldingen gjelder prosjektet:

28380	<i>Health Promotion Capacity Building: Norwegian Health Promotion Workforce</i>
<i>Behandlingsansvarlig</i>	<i>Universitetet i Bergen, ved institusjonens overste leder</i>
<i>Daglig ansvarlig</i>	<i>Elisabeth Fosse</i>
<i>Student</i>	<i>Ausra Fehlker</i>

Personvernombudet har vurdert prosjektet og finner at behandlingen av personopplysninger er meldepliktig i henhold til personopplysningsloven § 31. Behandlingen tilfredsstiller kravene i personopplysningsloven.

Personvernombudets vurdering forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven/-helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

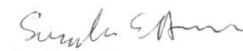
Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, <http://www.nsd.uib.no/personvern/prosjektoversikt.jsp>.

Personvernombudet vil ved prosjektets avslutning, 01.07.2013, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim


Sondre S. Arnesen

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Appendix 2a- Undersøkelse om norske helsefremmere

Kjære helsefremmer!

Universitetet ditt lurer på hva du driver med! Alle institusjoner som har ansvar for utdanning i folkehelse og helsefremmende arbeid i Norge har opprettet et nasjonalt nettverk for folkehelseforskning og utdanning. Nettverket mangler informasjon om hvilke jobber norske nyutdannede kandidater i helsefremmende arbeid får etter studiet. Dette behovet utviklet seg til et masteroppgaveprosjekt med tittel "Helsefremmende kapasitetsbygging. Norsk helsefremmende arbeidskraft". Målet med denne studien er å kartlegge hvilke jobber uteksaminerte studenter får etter studiet, og øke kunnskapen om hva det betyr å være en helsefremmer i Norge.

Studien har to separate deler. Den første delen som du ser nedenfor, er spørreskjemaet utformet for å kartlegge din nåværende arbeidssituasjon. Resultatene av studien vil bli publisert som gruppedata hvor enkeltpersoner ikke kan gjenkjennes.

For å få god oversikt, er det viktig at så mange som mulig fyller ut spørreskjemaet. Hvis du er i kontakt med andre kandidater som har utdanning i helsefremmende arbeid i Norge, vennligst del linken til dette spørreskjemaet med dem!

Den andre delen av studien vil omfatte telefonintervjuer med noen av dere som har fylt ut kontaklinformasjon i første delen av studiet. Intervjuet skal handle om arbeidsoppgaver og utfordringer i arbeidet ditt.

Deltakelse i begge deler av studien er frivillig, og du kan trekke deg fra den når som helst uten noen nærmere forklaring. Hvis du velger å trekke deg fra studien, vil alle opplysninger du har gitt bli slettet. All informasjon vil bli holdt konfidensielt, vil anonymiseres når oppgaven er ferdig og vil bli slettet innen 01.07.2013.

Innsendelse av dette spørreskjemaet vil bli sett på som ditt samtykke i å delta i første delen av studien.

Har du noen spørsmål eller kommentarer, vennligst ta kontakt med meg:

Ausra Fehlker 99 88 69 57 Ausra.Fehlker@stud.uib.no

eller veilederen min:

Elisabeth Fosse 93 04 77 42 Elisabeth.Fosse@iuh.uib.no

Takk for din deltakelse!

Hvor har du fullført utdanning i helsefremmende arbeid / folkehelse?

- Høgskolen i Gjøvik/Lillehammer/Hedmark
- Høgskolen i Vestfold
- Høgskolen i Bergen
- Universitetet i Bergen
- Universitetet for miljø og biovitenskap
- Norges Teknisk-Naturvitenskapelige Universitet

Eksamensår

Har du bachelor- eller mastergrad i helsefremmende arbeid / folkehelse?

- Bachelorgrad
- Mastergrad

Har du fullført annen utdanning før studiet i helsefremmende arbeid / folkehelse?

Hvis ja, innen hvilket område?

Har du fullført annen utdanning etter studiet i helsefremmende arbeid / folkehelse?

Hvis ja, innen hvilket område?

Har du vært arbeidsledig etter studiet?

Hvis ja- hvor lenge?

Hvor mange stillinger har du hatt etter fullført utdanning?

- Nåværende stillingen er min første
- 2-4
- 5 eller flere

Hvilken kommune arbeider du i ?

Nåværende arbeidsgiver (-e) og stilling (-er)

Stillingen din / stillingene dine er:

- Fast, heltid
- Fast, deltid
- Phd kandidat
- Tidsbegrenset, heltid
- Tidsbegrenset, deltid
- Heltid student
- Arbeidsledig

Hvor lenge har du vært ansatt i denne stillingen?

Vil du si at du utfører helsefremmende arbeid/bruker utdanningen din i din nåværende stilling?

- Ja, jeg utfører helsefremmende arbeid / bruker utdanningen min fortløpende i min nåværende stilling
- Ja, jeg har mange muligheter til å utføre helsefremmende arbeid / bruke utdanningen min i min nåværende stilling
- Jeg har få muligheter for å utføre helsefremmende arbeid / utdanningen min er lite brukt i min nåværende stilling
- Jeg har få muligheter for å utføre helsefremmende arbeid, men utdanningen min er brukt på en annen måte i min nåværende stilling
- Nei, jeg har ikke mulighet å utføre helsefremmende arbeid / bruke utdanningen min i min nåværende stilling
- Andre

Har du tatt noen kurs før du var ansatt i din nåværende stillingen?

Hvis ja- innen hvilket område?

Har du tatt noen kurs mens du har vært ansatt i din nåværende stillingen?

Hvis ja- innen hvilket område?

Har du behov for å utdype / forbedre kunnskapen din innen noen av områdene nedenfor?

- Nei, jeg har ikke behov for utdype kunnskapene mine innen helsefremmende arbeid
- Teori og etikk i helsefremmende arbeid
- Ledelse og kommunikasjon
- Planlegging helsefremmende aktiviteter
- Gjennomføring av helsefremmende aktiviteter
- Evaluering og behovsvurdering

Andre område?

Du er:

- Kvinne
- Mann

Har du lyst å få ferdig resultater sent til e-posten din?

Vil du samtykke i å delta i et telefonintervju angående din arbeidserfaring? Hvis ja, vennligst fyll ut din kontaktinformasjon (telefonnummer eller e-post adresse)

Eventuelle kommentarer?

Continue

Appendix 2b- An online questionnaire in English

Dear health promotion graduate!

Your university is wondering how you are doing! All the institutions responsible for health promotion education in Norway have recently created a National Network for Health promotion and Education. The network needs to know what jobs do health promotion graduates get after studies. This need evolved into a master's project with a title "Health promotion capacity building. Norwegian health promotion workforce" The goal with this study is to map what jobs health promotion graduates get after studies, and increase the knowledge of what it means to be a health promoter in Norway.

The study has two separate parts. The first part is an online questionnaire designed to map your current job situation. The results of this study will be published as group data where individuals could not be recognised.

To get as good overview it is important that as many as possible fill out the questionnaire. If you are in contact with other health promotion graduates please share the link to this study with them!

The second part of the study will include telephone interviews where I will ask you about tasks and challenges of your work.

Participation in both parts of the stud is voluntary, and you may withdraw your consent at any time without any explanation. If you decide to withdraw your consent, all data provided by you will be deleted. All information will be held confidentially, will be anonymised when the task is done and deleted until 01.07.2013

Submission of this questionnaire will be seen as your consent to participate in the first part of the study.

If you have any questions or comments, please contact me:

Ausra Fehlker (+47) 99 88 69 57 Ausra.Fehlker@student.uib.no or my supervisor:

Elisabeth Fosse 93 04 77 42 Elisabeth.Fosse@uih.uib.no

Thank you for participation!

Where did you complete the health promotion education?

- Høgskolen i Bergen
- Høgskolen i Gjøvik/ Lillehammer/ Hedmark
- Høgskolen i Vestfold
- Universitetet i Bergen
- Universitetet for miljø og biovitenskap
- Norges Teknisk- Naturvitenskaplige Universitet

Year of graduation

Your education in health promotion is

- Bachelor
- Master

Have you completed another education after studies in health promotion? If yes, in which field?

Have you completed another education before studies in health promotion? If yes, in which field?

Were you unemployed after the studies? If yes- how long?

How many jobs did you have after your studies in health promotion?

- The current job is my first
- 2 - 4
- 5 or more

Which municipality are you employed at?

Your current employer (-s) and the position (-s)

Your current position (-s) is/are

- Full time, permanent position
- Full time, temporary position
- PhD candidate
- Part-time, permanent position
- Part-time, temporary position
- Unemployed

How many years are you employed at this position

Would you say that you do health promotion/ use your education in the current position?

- Yes, I do health promotion/ use my education continuously in the current position?
- Yes, I have many possibilities to do health promotion/ use my education in the current position?
- I have few possibilities to do health promotion/ use my education in the current position?
- No, I do not have any possibilities to do health promotion/ use my education in the current position?
- Other

Have you taken any courses before you were employed at the current position? If yes- in which field?

Have you taken any courses while you were employed at the current position? If yes- in which field?

Do you need to deepen your knowledge in any of the fields below?

- No, I don't need to deepen my knowledge in health promotion
- Health promotion theory and ethics
- Leadership and communication
- Planning health promotion projects
- Implementation of health promotion projects
- Evaluation and needs assesment

Other fields?

You are

- Female
- Male

If you wish to receive results of this study when they are ready, please fill in your e-mail address.

Would you agree to participate in a telephone interview regarding your work experience? If yes, please fill in your contact information (phone number or e-mail address)

Any comments?

Appendix 3a – a recruitment e-mail for the online questionnaire (Norwegian)

Kjære helsefremmer!

Universitetet ditt lurer på hva du driver med!

Alle institusjoner som har ansvar for utdanning i folkehelse og helsefremmende arbeid i Norge mangler informasjon om hvilke jobber uteksaminerte studenter får etter studier. Dette behovet utviklet seg til et masteroppgaveprosjekt hos Universitetet i Bergen med tittel "Helsefremmende kapasitetsbygging. Norsk helsefremmende arbeidskraft".

Målet med denne studien er å kartlegge hvilke jobber uteksaminerte studenter får etter studiet, og øke kunnskapen om hva det betyr å være en helsefremmer i Norge.

Nedenfor kan du se en link til nettbasert spørreundersøkelse utformet for å kartlegge din nåværende arbeidssituasjon. Resultatene av studien vil bli publisert som gruppedata hvor enkeltpersoner ikke kan gjenkjennes. Deltakelse i denne studien er frivillig, og du kan trekke deg fra den når som helst uten noen nærmere forklaring.

Du trenger bare få minutter for å fylle ut skjemaet.

<http://skjemaker.app.uib.no/view.php?id=128>

Takk for din deltakelse!

Med vennlig hilsen,
Ausra Fehlker

Appendix 3a – a recruitment e-mail for the online questionnaire (English)

Dear health promoter!

Your University is wondering how you are doing!

All institutions responsible for education in public health and health promotion in Norway lack information about what jobs their graduates get after studies. This need has developed into a thesis project at the University of Bergen, with a title "Health promotion capacity building. Norwegian health promotion workforce".

The aim of this study is to map what jobs health promotion graduates get after the study, and increase knowledge about what it means to be a health promoter in Norway.

Below you can see a link to the online survey designed to map your current work situation. The results of the study will be published as a group of data where individuals cannot be recognized. Participation in this study is voluntary and you can withdraw from it at any time without any explanation.

You only need a few minutes to fill out the form.

<http://skjemaker.app.uib.no/view.php?id=128>

Thank you for your participation!

With kind regards,
Ausra Fehlker

Appendix 4a- a recruitment e-mail for an interview (Norwegian)

Kjære helsefremmer!

Du har fått denne e-posten fordi du har fylt ut din kontaktinformasjon i den første delen av et masteroppgaveprosjekt med tittel "Helsefremmende kapasitetsbygging. Norsk helsefremmende arbeidsstyrke". Målet med denne delen av studien er å få en oversikt over hva det betyr å være en helsefremmer i Norge. I et telefonintervju vil jeg spørre deg om din utdanning, arbeidsoppgaver og utfordringer i arbeidet ditt.

Jeg er en utenlandsk student i helsefremmende arbeid, internasjonal retning ved universitet i Bergen. Jeg har gått på norskkurs i to år, men jeg mener at det kan være litt utfordrene for meg til å bruke språket riktig i et telefonintervju med deg. Derfor ønsker jeg å vise deg spørsmålene jeg har planlagt å stille deg under intervjuet (se vedlegg).

Hvis du samtykker i å delta i et telefonintervju, vennligst send meg en e-post med tidspunktet (og telefonnummer) det passer best for deg at jeg ringer. Hvis du samtykker, ønsker jeg å bruke lydbånd. I etterkant blir intervjuene fra disse lydbåndene transkribert.

En telefonsamtale tar bare ca. 10-20 minutter, og jeg er veldig fleksibel når det gjelder tidspunktet (fleste dager er det fra kl.07:00 til 22:00).

Deltakelse i denne studien er frivillig, og du kan trekke deg når som helst uten noen nærmere forklaring. I den ferdige oppgaven svarene vil bli anonymisert. Alle opplysninger du oppgir vil bli tilgjengelig bare for meg, og vil bli slettet innen 01.07.2013. Lydopptak vil bli slettet innen to måneder etter intervju.

Har du noen spørsmål eller kommentarer, vennligst ta kontakt med meg eller veilederen min.

Ausra Fehlker 99 88 69 57 Ausra.Fehlker@stud.uib.no

Elisabeth Fosse 93047742 Elisabeth.Fosse@iuh.uib.no

Med vennlig hilsen,
Ausra Fehlker

Appendix 4b – a recruitment e-mail for an interview (English)

Dear health promoter!

You have received this email because you have filled out your contact information in the first part of a thesis project entitled "Health promotion capacity building. Norwegian health promotion workforce". The aim of this part of the study is to gain an overview of what it means to be a health promoter in Norway. In a telephone interview I will ask you about your education, work tasks and challenges in your work.

I am a foreign student in the international direction of health promotion studies at the University of Bergen. I have attended a Norwegian course for two years, but I think it might be a bit challenging for me to use the language correctly in a telephone interview with you. Therefore, I want to show you the questions I have planned to ask you during the interview (see Appendix).

If you agree to participate in a telephone interview, please send me an e-mail with the time (and phone number) that fits best for that I call. If you agree, I want to use a tape recorder. Later the interviews from the tapes will be transcribed.

A phone call takes only approx. 10-20 minutes, and I am very flexible terms of time (most of the days it is from kl.07:00 to 22:00).

Participation in this study is voluntary and you can withdraw at any time without any further explanation. In the final task of the responses will be anonymous. All information you provide will be accessible only to me, and will be deleted within 01.07.2013. Sound recordings will be deleted within two months after the interview.

Do you have any questions or comments, please contact me or my supervisor.

Ausra Fehlker 99 88 69 57 Ausra.Fehlker @ stud.uib.no

Elisabeth Fosse 93047742 Elisabeth.Fosse @ iuh.uib.no

With kind regards,

Ausra Fehlker

Appendix 5a- An interview guide for the telephone interview (Norwegian)

Spørsmål til telefonintervjuet

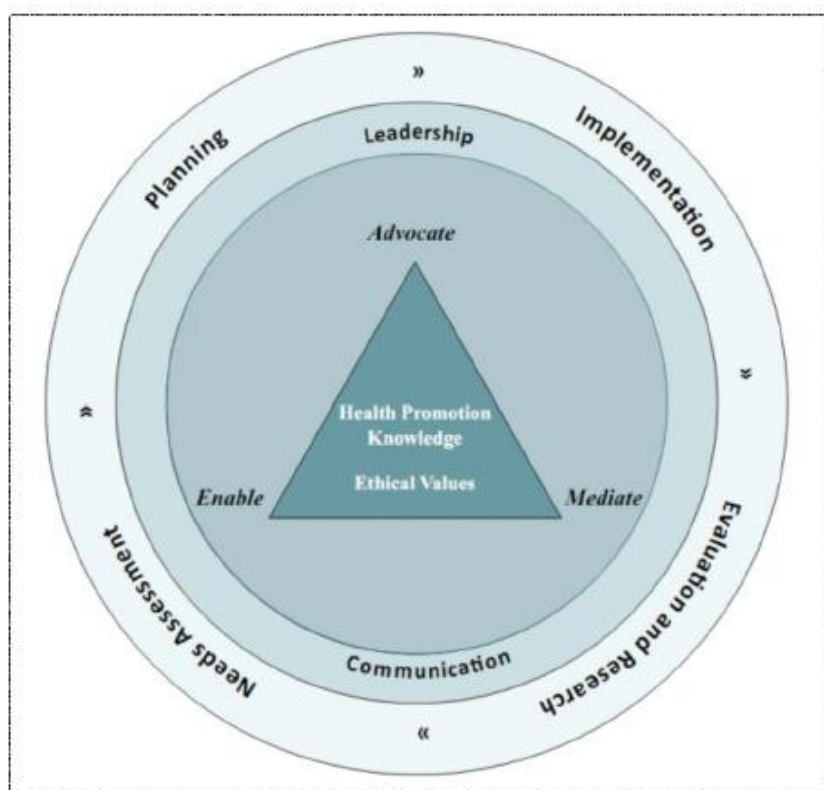
- Kan du fortelle litt om ditt valg om å studere helsefremmende arbeid? Hvilke forventninger hadde du da?
- Har forventninger forandret seg gjennom studiene?
- Kan du fortelle meg litt om prosessen med å søke jobb etter studiene? Hvordan søkte du på jobb?
- Vet du om hvor mange som søkte stillingen som du ble ansatt i?
- Hva var viktig for din arbeidsgiver i ansettelsesprosessen? Hvilke kompetanser lette de etter?
- Kan du beskrive en vanlig arbeidsdag i din nåværende stilling?
- Hva gir mest mening i jobben din?
- Hva er mest utfordrene i arbeidet ditt?
- Har du gitt noen form for opplæring i helsefremmende arbeid til dine kolleger?
- Hva er din mening om akkreditering* av helsefremmende utdanning? Tror du akkreditering kan gjøre det lettere for helsefremmere å søke jobb?

*Å akkreditere helsefremmende arbeid betyr at det lages standarder for hvilke kunnskaper og ferdigheter en person med utdanning i helsefremmende arbeid bør ha.

I februar 2011 har EU-prosjektet CompHP ("Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe", som jobber med europeiske mål for utdanning/kompetanse innenfor feltet helsefremmende arbeid), publisert en modell for kompetanser innen helsefremmende arbeid (se bilde og beskrivelse nedenfor).

Denne modellen er ny og derfor vil jeg gjerne stille deg noen spørsmål for å finne ut om/hvordan modellen fungerer i praksis.

- Har du hørt om denne modellen før?
- Hvilke helsefremmende arbeidsmetoder (fremme, megle, muliggjøre) bruker du mest i arbeidet ditt?
- Hvor viktig er lederskaps- og kommunikasjons evner i arbeidet ditt?
- Behovsvurdering, planlegging, gjennomføring og evaluering av helsefremmende aktiviteter. Dette er en teoretisk beskrivelse av en helsefremmende arbeidsprosess. Kan du fortelle hvor mye denne beskrivelsen passer daglig praksis i ditt arbeidsliv?
- Hvordan mener du modellen beskriver kompetanser i helsefremmende arbeid i forhold til din arbeidserfaring?



Det innerste feltet (*health promotion knowledge and ethical values*) viser at teori og verdier om helsefremmende arbeid er ”i hjertet” av alle andre kompetanser.

Det andre laget (*advocate, mediate, enable*) er kompetanser å bruke helsefremmende arbeidsretninger/ metoder: fremme, megle, muliggjøre

Det tredje laget (*leadership; communication*) viser kompetanser å lede og kommunisere.

Det fjerde/ ytterste laget viser kompetanser å organisere en helsefremmende arbeidsprosess: Behovsvurdering → planlegging → gjennomføring → evaluering av helsefremmende arbeid.

Takk for din deltakelse!

Med vennlig hilsen,
Ausra Fehlker

Appendix 5b- An interview guide for the telephone interview (English)

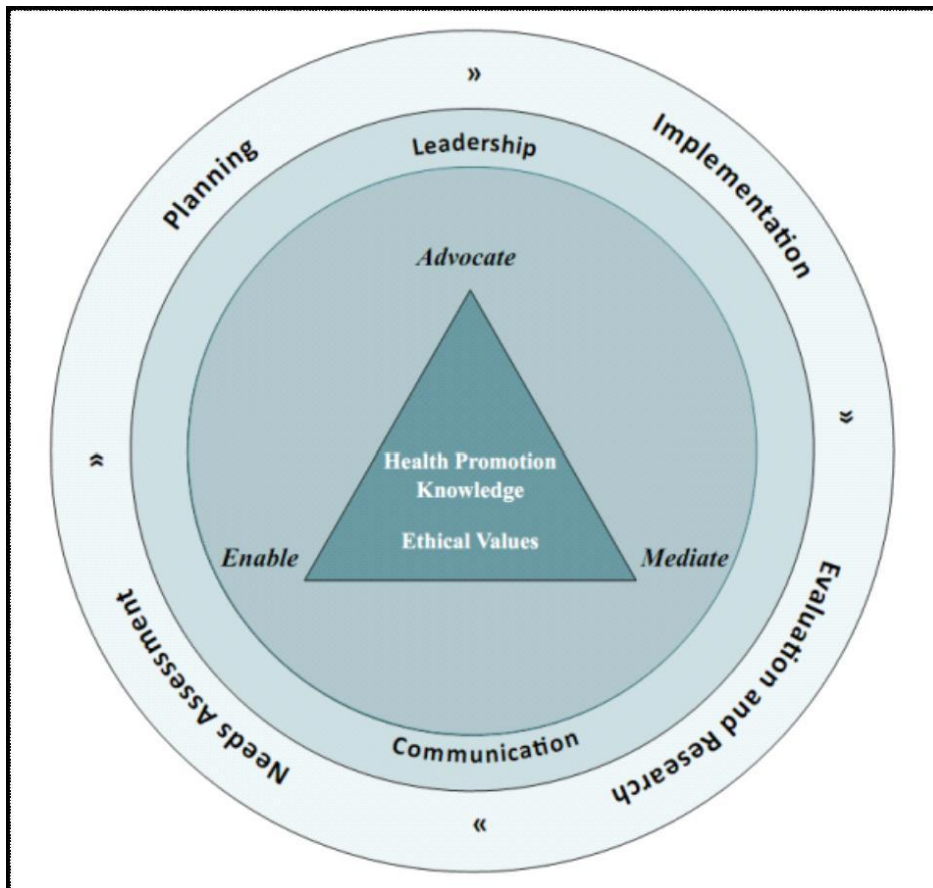
- Can you tell us about your choice to study health promotion? What expectations did you have then?
- Have expectations changed over the time of the study?
- Can you tell me a little about the process of applying for a job after graduation?
- Do you know how many people applied for the position that you were employed?
- What was important to your employer in the hiring process? What competencies have they looked for?
- Can you describe a typical workday in your current position?
- What is most meaningful in your job?
- What is most challenging in your work?
- Have you given any training in health promotion to your colleagues?
- What is your opinion about the accreditation * of health education? Do you believe accreditation can make it easier for health advocates to apply for a job?

* Accreditation of health promotion education means the creation of standards for the knowledge and skills a person with training in health promotion should have.

In February 2011, the EU project CompHP ("Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe", working with European objectives for education / skills in the field of health promotion), published a model for competencies in health promotion (see picture and description below).

This model is new and therefore I would like to ask you some questions to find out if / how the model works in practice.

- Have you heard about this model before?
- Which health promotion work methods (enable, mediate, advocate) do you use the most in your work?
- How important are leadership and communication skills in your work?
- Needs Assessment, planning, implementation and evaluation of health promotion activities is a theoretical description of a healthy promoter's work process. Can you tell how much that description fits the common practice in your workplace?
- How do you feel model describes competencies in health promotion in relation to your work experience?



The inner field (Health promotion knowledge and Ethical values) shows that the theory and values of health promotion is "the heart" of all other competencies.

The second layer (Advocate, Mediate, Enable) are the competencies to use health promotion methods: Advocate, Mediate, Enable.

The third layer (leadership, communication) shows the competencies to lead and communicate.

The fourth / outer layer shows the skills to organize a health promotion work process: Needs Assessment → Planning → implementation → evaluation of health promotion.

Thank you for your participation!

With kind regards,
Ausra Fehlker