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UNION INTERNATIONALE DE PROMOTION DE LA SANTÉ ET D'ÉDUCATION POUR LA SANTÉ
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Scoping Study

Health Promotion Workforce Capacity and Education and Training Needs in Low and Middle Income Countries

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TABLE OF CONTENTS

Acknowledgements

The IUHPE Scoping Study on Health Promotion Workforce Capacity and Education and Training Needs in low and middle income countries was developed in collaboration with members of the IUHPE Global Board of Trustees and the staff of the IUHPE Head Office in Paris. Their support and active engagement, and that of Health Promotion colleagues around the world, was essential to the successful completion of the scoping survey.

EXECUTIVE SUMMARY

This scoping study aimed to identify current capacity for Health Promotion and the priority education and training needs for capacity development in low and middle income countries (LAMICs). Despite a low response rate (35% comprising responses from 37 countries), the findings of the study provide a 'snap shot' of current capacity for Health Promotion and the training and education needed to maintain and further build capacity in low and middle income countries across the IUHPE regions. The opinions of the respondents on the role which the IUHPE can play to support capacity development also provide a useful basis for future IUHPE strategies.

Key findings include:

- The term most commonly used for health improvement activities in the majority of countries responding was Health Promotion.
- There was an identifiable Health Promotion unit or department in Ministries for Health in the majority of countries responding.
- There were dedicated posts with the title 'Health Promotion' in slightly over half of the countries responding.
- Health Promotion formed part of overall health policies for the majority of countries responding; however,11% reported having neither Health Promotion policies nor Health Promotion input into other policies.
- Funding was available from both governmental and nongovernmental sources for the majority of countries responding. Funding was generally described as limited, project specific and not sustained.
- 'Strengthening community action' was rated as the Ottawa Charter 'action area' most frequently employed in Health Promotion strategies.
- There was very strong support for a dedicated Health Promotion workforce with specialised training in all countries responding.
- The majority of respondents reported the existence of education and training for Health Promotion but also considered that the current provision was not adequate to build and maintain capacity for Health Promotion.
- The currently available education and training for Health Promotion was generally reported as being relevant and culturally appropriate.

- The main drivers for education and training in Health Promotion identified were:
    - Existing education/training institutions
    - Existing workforce/partners
    - Demand for qualified health promoters
    - Positive policy context

- The main barriers to education and training in Health Promotion identified were:
    - Job/employment availability
    - Economic and social context
    - Lack of understanding of Health Promotion/best practice
    - Lack of courses and qualified teachers

- Less than a quarter of those responding (22%) had access to competency frameworks for Health Promotion.

- Accreditation for Health Promotion was rated as important or very important by 58% of those responding.

- The education and training needs which were rated as most important were 'enabling change' and 'knowledge competencies'.

- 'Basic foundation level courses' and 'continuing professional development courses' for Health Promotion professionals' were rated as the types of Health Promotion education and training most required.

- Health Promotion practitioners, followed by primary care professionals, were rated as the highest priority target groups for training and education.

- Face-to-face lectures and workshops were identified as the most useful methods of delivery for education and training for Health Promotion, while distance learning through online courses materials was the least favoured method.

- Access to information on Health Promotion by those undertaking Health Promotion activities was rated as not being adequate by a majority of those responding.

- 'Strong leadership provided by key individuals and organisations', followed by 'commitment of the existing workforce' were the key existing strategies and assets in relation to capacity building for Health Promotion rated as most important.

- The majority of those responding (69%) stated that they were not aware of networks to support education and training in Health Promotion in their country or region.

- The IUHPE was clearly identified as the organisation which should take a lead role in education and training for Health Promotion at regional and global levels, closely followed by the World Health Organisation.

- Few of the respondents had made requests for support on education and training for Health Promotion from the IUHPE. Mixed responses to such requests were reported.
- The low response rate limited in-depth comparison of findings across the regions. The differences noted, however, indicate the need for further investigation to ensure that future workforce capacity development is appropriate for different countries and contexts.

The findings of this scoping study, while somewhat limited by a low response rate, indicate useful points for consideration by the IUHPE when developing a strategic approach to workforce capacity development for Health Promotion. There is, for example, clear indication of support for a dedicated workforce with specialised training but also of limited and unsustained funding and few active practitioners with Health Promotion in their job title or description. Health Promotion units and departments are under pressure and, in at least one case a 'standalone' unit has recently closed down.

In order to build on existing assets and meet the needs identified by the respondents a workforce capacity development strategy will need to identify at what levels, and by what means, the IUHPE can best contribute to such development, including widening its role from training and education to encompass other capacity development roles. Additional roles could include:

- increased and more focused advocacy for Health Promotion as a core element of broader capacity development action
- developing and supporting partnerships and networks at regional and international levels
- developing criteria for competencies, standards and accreditation for Health Promotion to assure quality globally.

INTRODUCTION

Study Rationale

Workforce development is critical to building capacity for the effective delivery of Health Promotion actions. Supporting capacity building and training of the Health Promotion workforce is a central plank of building the infrastructure required for promoting health at the population level:

> *'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)

The overall goal of the IUHPE Vice President for Capacity Building Edcuation and Training (2007-2010) workplan was to support the capacity building, education and training of individuals, organisations and countries to undertake Health Promotion activities.This scoping study was undertaken to inform the processes required to meet this goal.

A Report developed by the IUHPE Vice-President for Strategy and Governance in 2008 (2), identified a number of key areas for action on capacity building including:

- the need for professionals trained in Health Promotion
- the need for sustainable funding for building capacity building
- the availability of accessible culturally relevant training, and education
- the lack of opportunities for exchanging information and skills development.

The report concluded that further consultation should be undertaken in the IUHPE regions to identify priority training and development needs for building a competent Health Promotion workforce. This scoping study thus leads from, and is informed by, this report.

Aim of the Scoping Study

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

Objectives

- To explore the terms most commonly used for Health Promotion activities.
- To investigate current capacity for Health Promotion in relation to existing policies, posts and funding.

- To examine the range of Health Promotion strategies employed and opinions on their appropriateness for best practice.
- To assess opinions on the need for a dedicated Health Promotion workforce with specialised training.
- To investigate existing education and training for Health Promotion and opinions on the adequacy of this to build and maintain capacity for Health Promotion.
- To ascertain opinions on the relevance and cultural appropriateness of existing education and training.
- To identify the main drivers for, and barriers to, education and training in Health Promotion.
- To ascertain the availability of competency frameworks for Health Promotion and opinions on the importance of accreditation for Health Promotion.
- To indentify priority education and training needs.
- To gather opinions on access to information on Health Promotion by those undertaking Health Promotion activities.
- To assess opinions on existing strategies and assets in relation to capacity building for Health Promotion.
- To investigate perceptions of the roles of regional and global networks for capacity building in Health Promotion.
- To report on respondents' experiences of requesting assistance for capacity building activity from the IUHPE.

Scope of the Report

This report comprises the findings of a scoping study on Health Promotion workforce capacity and education and training needs in low and middle income countries (LAMICs) undertaken at a global level in Spring 2010. The study focuses on LAMICs as there are differences of interpretation as to what constitutes 'countries with identified capacity needs', the term used in IUHPE strategies. The use of the World Bank listings of economic income (3) provided a definable sample frame for the study.

The report includes a list of education and training organisations identified by respondents, together with a list of Health Promotion resources collated by Mahmood and Barry (4). Recommendations for the future work of the IUHPE on workforce development, and on capacity development in general, are also included.

Background to the Scoping Study

In its simplest form capacity may be defined as:

> *'the ability of individuals, institutions and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner.' (5)*

Over the past two decades there has been a move away from the traditional concept of 'capacity building' focusing on technical training, to a more developmental approach reflected in the increasing use of the term 'capacity development'. Differences between the two terms and the underlying concepts of each can be understood from the following definitions:

> *'Capacity development commonly refers to the process of creating and building capacities and their (subsequent) use, management and retention. This process is driven from the inside and starts from existing capacity assets'.*

> *'Capacity building commonly refers to a process that supports only the initial stages of building or creating capacities and is based on an assumption that there are no existing capacities to start from. It is, therefore, less comprehensive than capacity development'. (5)*

The shift from capacity building to capacity development matches well with the principles of Health Promotion, as both emphasise enabling people to take control over their own learning and development using empowering and participative methods. Given the 'match' between capacity development and Health Promotion it is suggested that this term, rather than capacity building, maybe more appropriate for use in future IUHPE strategies.

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

> *'Capacity of a health professional, a team, an organisation or a health system is an ability to perform the defined functions effectively, efficiently and sustainably and so that the functions contribute to the mission, policies and strategic objectives of the team, organisation and the health system.' (6)*

The complexities of the interrelated elements which form the capacity context for workforce development are well demonstrated in Figure 1 (7).

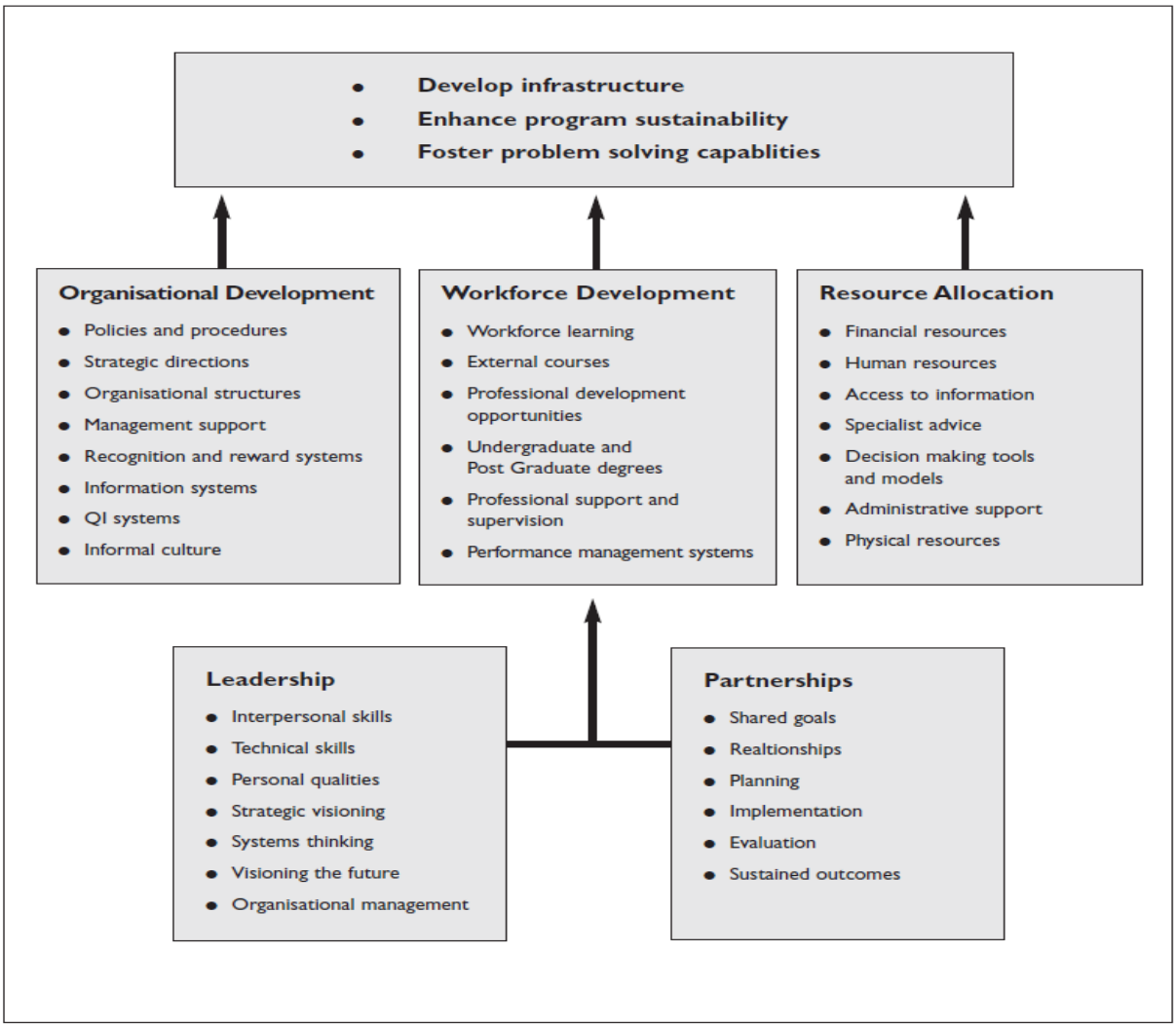

Figure 1 Capacity building framework adapted from NSW 2001 (7)

Capacity development in relation to Health Promotion has been defined as:

> *'the development of knowledge, skills, commitment, structures, systems and leadership to enable effective Health Promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for Health Promotion in organisations, and; the development of cohesiveness and partnerships for health in communities.' (8)*

In relation to capacity development for Health Promotion, Catford et al. (9) and Sparks (2), among others, emphasise that the concept of capacity varies according to context. Thus, capacity development initiatives must take cognisance not only of the local needs, but also of the existing strengths and assets available (2, 9).

> '*One of the complexities of Health Promotion is that there is no single 'one size fits all' in terms of intervention design. Responses have to be tailored to the issue, context and resources available'* (9).

There is clear indication that capacity development is crucial to the future of Health Promotion. Barry (10), for example, suggests that capacity building is key to the future growth and development of Health Promotion and that that it is timely to consider what infrastructure is required for sustainable implementation of effective practice for the future:

> *'It is clear that without the capacity to deliver on the political vision, core values, principles and key objectives of Health Promotion as outlined in World Health Organisation's directives, national policies and international agreements, the aims of Health Promotion will be aspirational only and will not be translated into effective practice and policy for population health improvement.'*

Successive World Health Organisation and IUHPE conferences on Health Promotion have focused on capacity development including:

- WHO Fifth Global Conference on Health Promotion in Mexico City in 2000 (11), which called for the development of countrywide plans to strengthen existing capacity for implementing strategies.
- IUHPE 18th World Conference on Health promotion and Health Education: Health 2004; 26.-30 April, 2004, Melbourne, Australia (12).
- WHO Sixth Global Conference on Health Promotion in Bangkok, Thailand, in 2005 (13), which included reports and discussion on mapping capacity for Health Promotion at a global level.
- IUHPE 19th World Conference on Health Promotion and Health Education: Health Promotion Comes of Age: Research, Policy & Practice for the 21st Century; 10.-15. June 2007, Vancouver, Canada (14).
- WHO Seventh Global Conference on Health Promotion in Nairobi, Kenya, in 2009 (15), which emphasised developing knowledge and skills for intersectoral collaboration and effective delivery as a means of achieving a critical mass of capacity for Health Promotion globally.

The Galway Consensus Conference Statement (16) also refers to the need to build capacity to achieve health improvement and indicates that this will require the global expansion of a competent Health Promotion workforce. Qualified 'human resources' in Health Promotion are recognised as being essential to deliver the quality Health Promotion actions identified in the core domains. Policies and interventions are, it is argued, only effective when they are relevant to the context in which they are applied. This argument reinforces the need for a skilled workforce capable of translating policies and plans into effective actions which are tailored to the relevant social, cultural, economic and political contexts (10, 7-20).

However, despite the wealth of information on what constitutes capacity and the need for workforce development, a lack of capacity for health improvement is also widely recognised in relation to Health Promotion and other professional, nongovernmental and community resources. Barry (10), for example, suggests that while the capacity to promote health in high-income countries is improving, in low and middle income countries it remains limited. The IUHPE has also concluded that there is a lack of capacity for Health Promotion globally:

> *'Workforce capacity and capability for Health Promotion is well developed in only a few countries, and under resourced or entirely lacking in many.'* (20)

Heller et al. (21) also observe that, while it is recognised that a trained workforce of health professionals is essential for health improvement, there is currently a lack of adequate capacity in low income countries. Gyapong and Ofori-Adjei (22) and Sparks (2) also raise the issue of retention of workforce capacity for health as a continuing challenge in low income countries.

The World Health Organisation has established the 'Global Health Workforce Alliance'[1] in response to this identified gap in capacity.[2] This Alliance may be a useful partner for the IUHPE when developing future strategies for capacity development in Health Promotion.

Sparks (2) summarised the major issues related to a lack of capacity for Health Promotion in low income countries as being the lack of:

- Professionals trained in Health Promotion due to a lack of political priority given to Health Promotion and of structures to provide ongoing capacity building.
- Sustainable resources for capacity building in Health Promotion including the funding of Health Promotion and of education and training.
- Access to relevant information, evidence and training in an appropriate language/cultural context.
- Sharing of information, experiences and skills due to language, financial, or geographical barriers, costs associated with travel, etc.
- Linkages across health systems and with other sectors resulting in Health Promotion not being seen as relevant to multiple government departments.

Reliance on a limited range of strategies or out-dated concepts or theoretical frameworks of Health Promotion is also noted.

[1] The Global Health Workforce Alliance (http://www.ghwa.org).

[2] It is interesting to note that the only organisation with an explicit Health Promotion remit listed as a member of the Alliance is the Ugandan Network for Workplace Health Promotion.

The IUHPE in its Shaping the Future of Health Promotion Report (2007) (18) specifically identified education and training needs:

> *'In all parts of the world there is a pressing requirement for further investment in the education and training of Health Promotion specialists, practitioners and other workers. Essential training should include: developing the knowledge and skills for advocacy and mediation with politicians and the private sector, assessing the impact of policies on health and its determinants, accessing and using available information and evidence, and evaluating interventions.'*

The need for an informed and strategic approach to the development of the Health Promotion workforce as a major element of capacity building is also well acknowledged. Workforce development was, until recently, equated with professional development and focused almost exclusively on the needs and development of the individual worker. More recently there has been a shift in focus to the organisational and strategic levels as the key to achieving sustainable workforce development, thus echoing the shift to 'capacity development' and the term 'development' is now also generally used in relation to the workforce.

It is clear, therefore, that there is ample evidence of the need to develop workforce capacity for Health Promotion. In taking action on workforce capacity development, the IUHPE can draw on a wide range of resources in relation to capacity development in general and workforce capacity development in particular. For example, a number of models of workforce development have been developed which range from comprehensive systems-based models to more individual/team based approaches, all of which view workforce development within a broad developmental context (7, 23-29). The need to focus beyond the current workforce and look towards the future is highlighted in a recent WHO publication (30) which emphasises that it is critical that future plans for Health Promotion workforce development include mechanisms for adjustment to ongoing changing circumstances.

The complexities of the processes and resources for future workforce planning and their interaction and interdependence are well illustrated in Figure 5 (30).

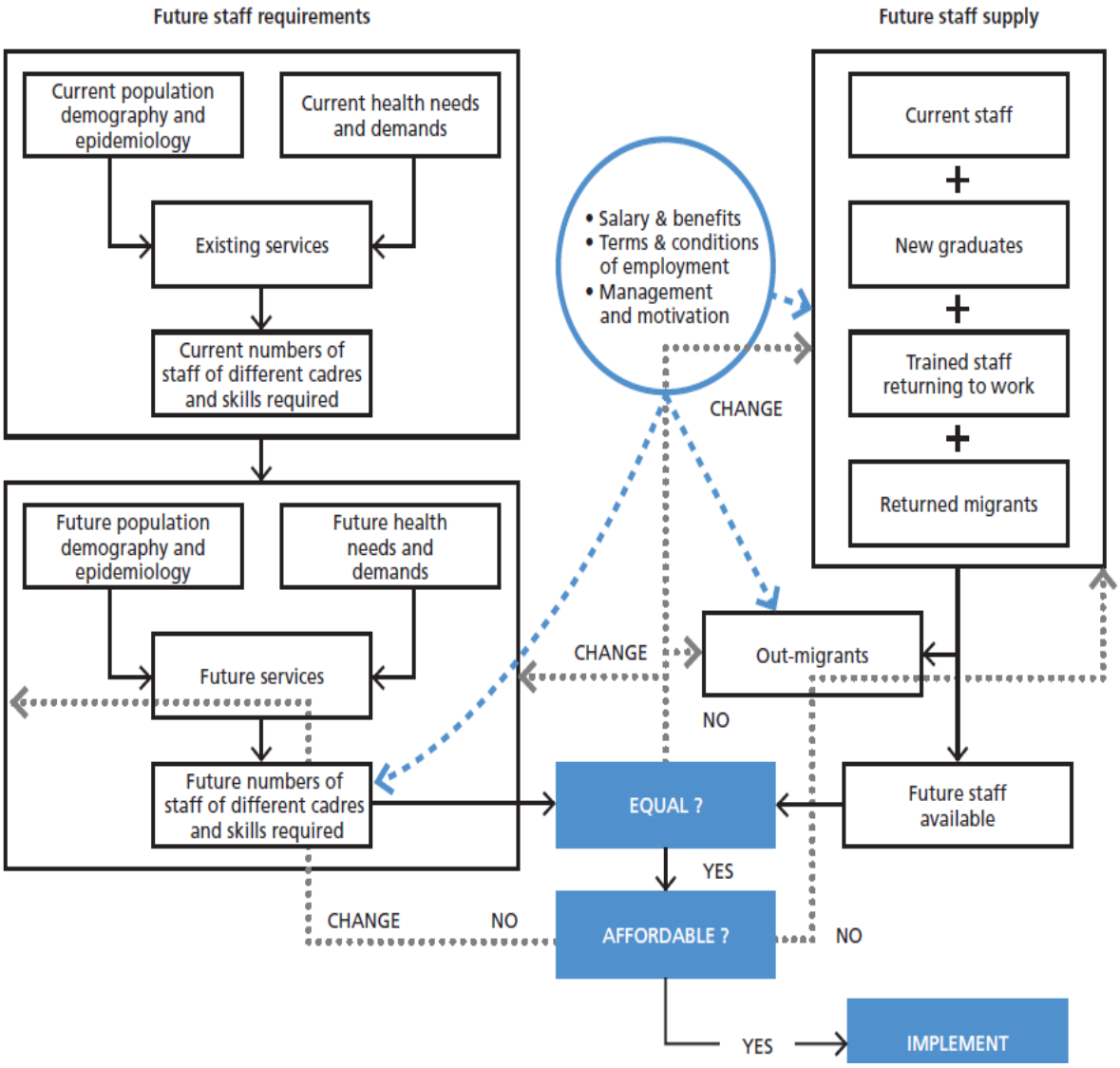

Figure 2 Processes and resources for future workforce planning adapted from WHO 2010 (30)

These and other workforce planning frameworks can be useful to the IUHPE when reviewing its strategy for workforce capacity development for Health Promotion. Part of that strategy, it is suggested, should be to inform, educate, research, and promote debate on the best approaches to Health Promotion workforce development at local, regional, national and international levels.

An important feature of capacity development, including workforce development, is that it focuses not only on needs but also on identifying, and building on, existing assets and strengths (2, 9, 31).

Sparks (2) categorised the strengths and assets identified in his 2007 report as:

- Community knowledge, tradition and culture.

- Eagerness to learn and to build capacity.
- Low-cost infrastructure which can lead to more sustainable Health Promotion capacity building outcomes.
- Political commitment, particularly in countries which have a political and values-based commitment to working in participatory ways.
- Existing workforce including NGO leaders, academics and health professionals.
- Existing training and education.
- Internet and global communication/networks.
- Civil society partnerships including community organisations and partnerships at multiple levels with NGOs, the private sector, local foundations and charitable organisations.

The recognition of, and linkage with, existing assets and strengths at all levels and in all contexts is, therefore, a pivotal consideration for the IUHPE if it is to be effective in workforce capacity development for Health Promotion globally.

In relation to workforce capacity, Howze et al. (32) suggest the following questions as a starting place for enhancing the capacity of Health Promotion practitioners in what they term 'developing' countries[3]:

- What constitutes optimal Health Promotion practice under what circumstances?
- What steps can be taken to build Health Promotion pre-service and in-service training programmes?
- What should be the standards to which Health Promotion practitioners are trained in developing countries?
- How will practitioners' competencies be evaluated?
- What changes need to be made in personnel systems to increase recruitment and retention of trained Health Promotion professionals in developing countries?
- What can Health Promotion professionals, professional organisations, and employers do to create supportive work environments?
- What can be done to create or strengthen professional networks and organisations if they do not exist or are weak?

These authors also refer to the development of accreditation of professional education and training as a useful contribution which can be made to the quality and value of the Health Promotion workforce in developing countries. There are also many references to the need for core competencies to guide practice, education and training at a global level (for example, 10, 14, 16).

[3] The order of the question has been changed to present what is considered a more logical sequence for the purpose of the study.

Information technology has also been suggested by Howze et al. (32), Sparks (2), and others, as a means of enabling all aspects of capacity development for Health Promotion but some concerns are also expressed as there may be limited access to technological resources in LAMICs (2).

Sparks (2) offers other recommendations for developing capacity for Health Promotion including:

- A strong need to build capacity within local educational institutions so that capacity building efforts can be more sustainable and locally relevant.
- Increased translation of information from and to dominant languages to address information gaps.

Mapping Health Promotion capacity is an approach identified to measure current status in Health Promotion capacity as a baseline for assessing progress (31). Various models of capacity mapping are available, including those developed by the WHO Regional Office for Europe (33) and in Australia (34). Another example is the 'National Health Promotion Capacity Wheel' (Figure 3), prepared for the World Health Organisation Conference in Bangkok (9).

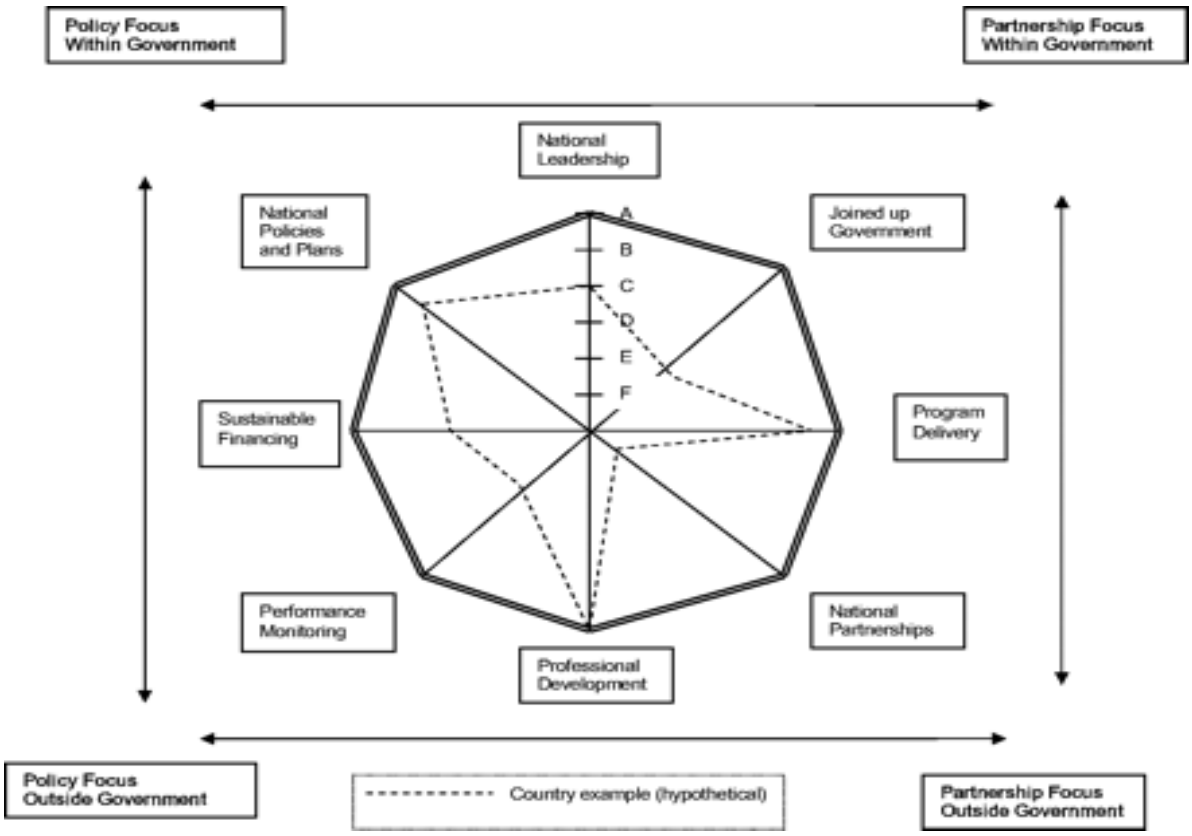

Figure 3 National Health Promotion Capacity wheel adapted from Catford 2005 (9)

In any mapping process or when considering capacity development for Health Promotion in 'countries with identified needs' it is important that the IUHPE review what constitutes such countries and how they can be identified. It can be argued that all countries have 'identifiable needs' in Health Promotion, considering that, as, Mittelmark (31) suggests, there is no reference to over capacity in Health Promotion in any country.

If other terms are used to define the priority countries for IUHPE strategies and action, such as 'low income' and 'developing' countries, it should be noted that these definitions may not be acceptable to many in the Health Promotion community. For example, Sparks (2) states that the term 'low income countries' has been described as inadequate to describe 'the breadth of contexts in which impoverished peoples struggle to improve their health'. In this context it is also important to note that, while international experience and support is undoubtedly useful to capacity development for Health Promotion in LAMICs, the advice on the need to match interventions to contexts must be heeded and note made that misjudged interventions can *'perpetuate the mythology of a more enlightened, capable and superior group of high income countries who condescend to 'help' poorer countries'*. (2)

In this context, the World Bank (3) classifies all low and middle income countries as 'developing' but notes:

> *'The use of the term is convenient; it is not intended to imply that all economies in the group are experiencing similar development or that other economies have reached a preferred or final stage of development. Classification by income does not necessarily reflect development status'*.

For the purposes of this report the definitions of low and middle income countries are those of the World Bank (3), which relate to economic income levels only and imply no comment on development status or value:

> *'Economies are divided according to 2009 GNI per capita and the groups are: low income, $995 or less; lower middle income, $996 - $3,945; upper middle income, $3,946 - $12,195; and high income, $12,196 or more'*.

METHODS

Sample

The sample identified for the study comprised all countries defined by the World Bank (3) as having low, lower middle or upper middle economic income. Initially the focus of the study was on countries with 'identified needs' as specified in IUHPE strategies but this proved difficult to operationalise. Consideration was also given to focusing on low income countries only, but as many of the countries listed as 'middle level income' were identified in the literature and through feedback from colleagues active in the IUHPE regions as having limited Health Promotion capacity, it was decided to widen the target audience. Some countries, for example, while enjoying middle level income, have recently experienced wars, changes in political systems and, most recently, catastrophic economic downturns, all if which impact on the capacity for Health Promotion.

A total of 145 countries[4] are listed globally by the World Bank as having Low, Lower Middle or Upper Middle economic incomes. These countries were grouped into the regions defined by the IUHPE.[5]

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

Figure 4 Map of WHO and IUHPE regions

[4] See Appendix 1

[5] These regions generally follow the World Health Organisation's regional boundaries, the exception being that the IUHPE divides the WHO's Western Pacific Region into two regions, namely the South West Pacific (SWP) and the Northern Part of the Western Pacific (NPWP).

The following sources were used to identify suitable respondents:

- Contact lists supplied by IUHPE Regional Vice Presidents
- IUHPE membership lists
- Country contacts identified by members of the IUHPE Global Board
- Lists of contacts developed for the CompHP Project[6] (EURO contacts)
- Contact list provided by CIPES[7]
- WHO contact lists available online
- Personal contacts of researchers

Contact details were initially identified for respondents in 115 countries[8]. However, the final number of countries included in the study was 107 as some contacts proved inaccessible.

Questionnaire

A questionnaire[9] was developed using a combination of closed and open questions and rating scales. The questions were designed to gather information on the key points identified in the Sparks report (2), issues on capacity development for Health Promotion identified in the literature, action areas identified in the Ottawa Charter (35) and the competency domains developed by the Galway Consensus Conference Statement (16).

The questionnaire focused on the following key dimensions:

- The terms most commonly used for Health Promotion activities.
- Current capacity for Health Promotion in relation to existing policies, posts and funding.
- The range of Health Promotion strategies employed and their appropriateness for best practice.
- The need for a dedicated Health Promotion workforce with specialised training.
- Existing education and training and the adequacy of this to build and maintain capacity for Health Promotion.
- The relevance and cultural appropriateness of existing education and training.
- The main drivers for, and barriers to, education and training in Health Promotion.
- The availability of competency frameworks for Health Promotion and the importance of accreditation for Health Promotion.
- Priority Health Promotion education and training needs.
- Access to Health Promotion information by those undertaking health improvement.
- Existing strategies and assets in relation to capacity building for Health Promotion.
- Perceptions of the roles of regional and global networks for capacity building in Health Promotion.

[6] http://www.iuhpe.org/index.html?page=614&lang=en
[7] http://www.cipespiemonte.it/iuhpe-cipes2.php
[8] See Appendix One
[9] See Appendix Two

- Experiences of requesting assistance for capacity building activity from the IUHPE.

The questionnaire was piloted by sending the first draft to one respondent in each of the six IUHPE regions. The revised questionnaire was then made available to respondents via a link in an email to the Survey Monkey online research tool.

FINDINGS

Response and Respondents across all regions

Response

Despite email reminders and an extension of the deadline for returning the questionnaires, the final response was 39 numbered from 37 countries[10], a response rate of 35%. The greatest number of replies came from the EURO (36%)[11] and the AFRO Regions (25%), with the lowest response from the EMRO Region.

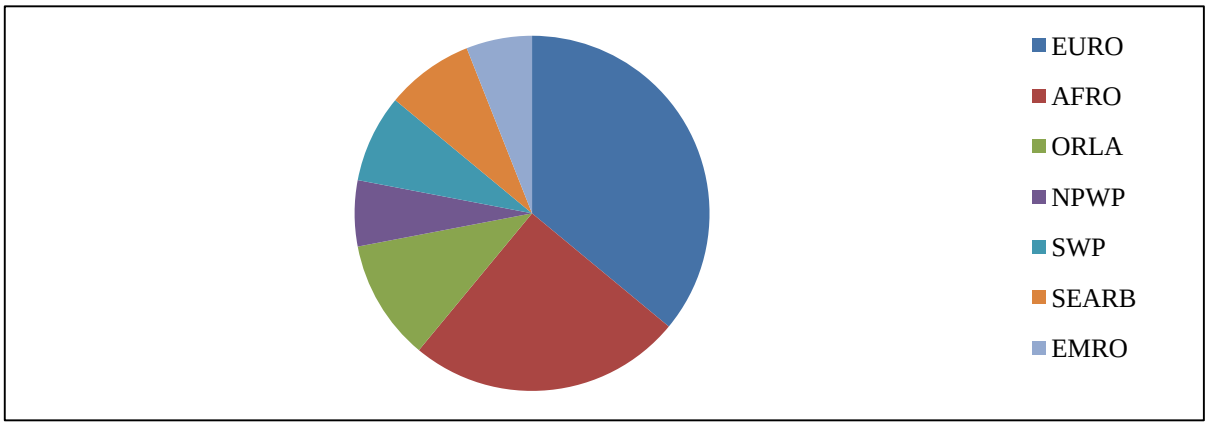

Figure 5 Response rate by IUHPE regions (%)

Most respondents were from the academic sector (47%), followed by equal numbers from nongovernmental organisations (NGOs) and the statutory sector (22%). Two respondents indicated that they worked in both the academic and statutory sectors and the remainder chose the option 'other' and did not give further details.

Results

Terms used for health improvement activities

Health Promotion was reported to be the term most frequently used for health improvement activities. 'Health Improvement (Amélioration de la santé)' and 'Prevention' were the terms other than Health Promotion, Public Health or Health Education reported as being used. In one country it was noted that, while governmental organisations used the term Public Health exclusively, some NGOs used Health Promotion, a difference in usage also noted in relation to job titles (see page 26).

[10] One of the respondents was interviewed by telephone.
[11] In the EURO region there were three replies from one country and two from another. Other regions had one response per country.

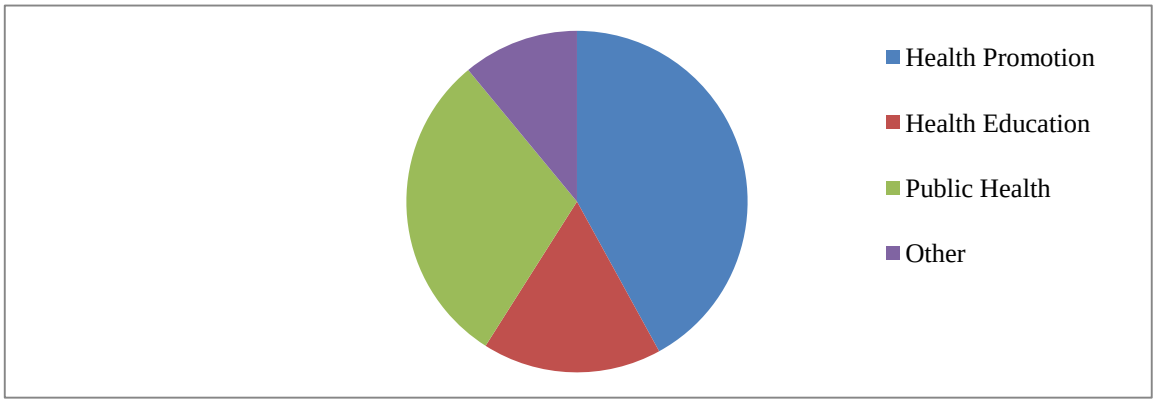

Figure 6 Term used to describe health improvement activities (n=36)

Current capacity for Health Promotion - policies, posts and funding

The majority of respondents (78%) reported that there was an identifiable Health Promotion unit, section or department within their country's Ministry for Health. Over half (58%) reported that there were dedicated posts with the title 'Health Promotion' in their country. These posts were mainly located within Ministries for Health and NGOs, with one reference to posts in the private sector. It was indicated that the job title Health Promotion was not common in French speaking countries:

> *'Health Promotion is) probably used in the policy 'jargon', or could be in use in some NGO'S, but it is not common to hear specifically this title.'*

A recent change of job title at national level was noted in another country:

> *'All officers, previous Health Education Officers in the Ministry of Health, are now officially designated as Health Promotion Officers, Health Promotion specialist or coordinators, etc.'*

Health Promotion formed part of overall health policies for the majority of those responding but 11% had no Health Promotion policy of any type. The focus of health improvement in one of these countries was described as 'medical, epidemiological and curatively focused.'

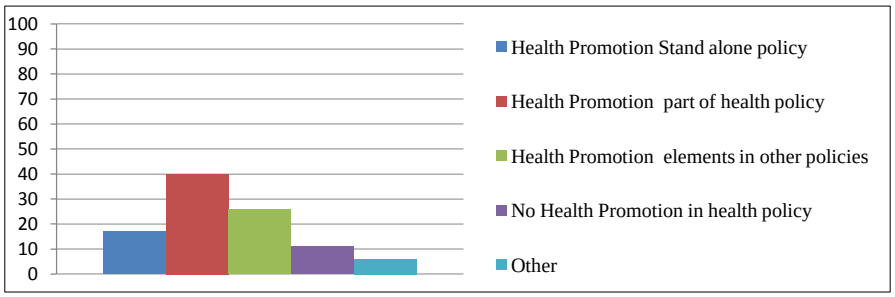

Figure 7 Presence of Health Promotion in health and other governmental policies (N=35)

While the majority of those responding indicated that there was dedicated governmental funding for Health Promotion (60%), precise figures for the amounts allocated were generally not available. Funding for Health Promotion was described as often being integrated into overall health budgets, with the result that detailed breakdowns on specific budgets were not easily accessed. Some respondents provided an overview of the funding available, for example, '*1% from health care budget'* and *'very low, less than 2%*'. Most also commented on the low levels of sustained funding for Health Promotion usually available from governments.

A significant majority (89%) of those responding reported that funding for Health Promotion activities was also available from other sources. Some sources were identified only by the type of organisation, for example:

NGOs - local and international donors (not *specified*)

- Global Fund to Ministry of Health
- International donors through foreign governments
- International donors popularly known as development partners
- Global Fund (TB and HIV/AIDS)

Others give more specific information on funding sources including:

- UNFPA (United Nations Population Fund))[12]
- UNICEF (United Nations Children's Fund)[13]
- WHO (World Health Organisation)[14]
- UNRWA (United Nations Reliefs and Works Agency)[15]
- other UN agencies (unspecified)
- USAID (United States Agency for International Development)[16]
- SPC (Secetrariat of the Pacific Community)[17]
- AUSAID (Australian Government Overseas Aid Program)[18]
- EU funds
- National NGOs such as Jordan Association for Development of Women, Jordan Public Health Association, Royal Health Awareness Society.

Few details of the amount of funding supplied from nongovernmental sources were available and it was reported that annual amounts are 'variable or depended on specific projects'. Only two respondents quoted actual figures: '*circa 1 Million USD' and' International donors*

[12] http://www.unfpa.org/public/
[13] http://www.unicef.org/
[14] http://www.who.int/en/
[15] http://www.unrwa.org/index.php
[16] http://www.usaid.gov/
[17] http://www.spc.int/php/
[18] http://www.ausaid.gov.au/

- *$144,200'.* Others noted that while funding for health activities was available it was not 'with the title of Health Promotion'.

It was also noted that funding for Health Promotion activities from international donors was '*small and non-sustained'* and that '*while there are Structural and Cohesion Funds available for NGOs, Health Promotion is not an explicit priority within this funding* '.

These findings suggest a role for the IUHPE in advocating for the inclusion of sustained and sustainable funding for Health Promotion as an integral part of funding for capacity development by international NGOs and other donor organisations.

Health Promotion strategies employed

'Strengthening community action' was rated as the Ottawa Charter 'action area' most frequently employed, with 'reorienting the health service' rated as the least frequently employed.

Action Area	**Rating average**[19]
Developing personal skills	2.53
Reorienting Health service	1.97
Creating supportive environments	2.31
Strengthening community action	2.69
Building healthy public policy	2.54

Table 1 Frequency of employment of Ottawa Charter action areas

The effectiveness and sustainability of the strategies used in Health Promotion was reported as '*varying significantly*' in one country. It was also reported that in one country in the past three years the situation of Health Promotion had worsened and that a 'standalone' Health Promotion unit had been closed. A Health Promotion policy was described as having been 'pending' for 10 years in one country, but positive progress was reported in another as Health Promotion strategies were described as:

> *'now ongoing with the development of documents that support the concept at country level based on what is available at the regional level'.*

A small majority of those responding (51%) considered that the focus for the Health Promotion activities in their country was not appropriate for best practice. One respondent

[19] Rating range 1-4 where 1 = not employed, 2= infrequently employed 3 = frequently employed, 4= very frequently employed.

noted that although Health Promotion is part of activities related to disease preventive, Health Promotion '*per se'* receives less priority.

Opinions on need for a dedicated Health Promotion workforce with specialised training

A large majority of those responding (94%) considered that there was a need for a dedicated Health Promotion workforce with specialised training in their country. It was suggested that without a dedicated workforce:

> '*There is use of wrong approaches. Policies are not based on the local realities, but try to stick in international orientations and guidance. Local thinking is not used to address local health problems. Anthropological and/or sociological understanding of health issues is not an established culture.'*
>
> *'The complexities of Health Promotion are often being reduced to a simplistic approach mainly based on media campaigns with a tendency to ignore or resist the parts of Health Promotion which focus on participation and empowerment'.*

The lack of employment opportunities was identified as the main reason given for the few negative replies.

Existing education and training

While the majority of those responding reported the existence of some form of Health Promotion training or education in their countries, five countries reported having none (14%).

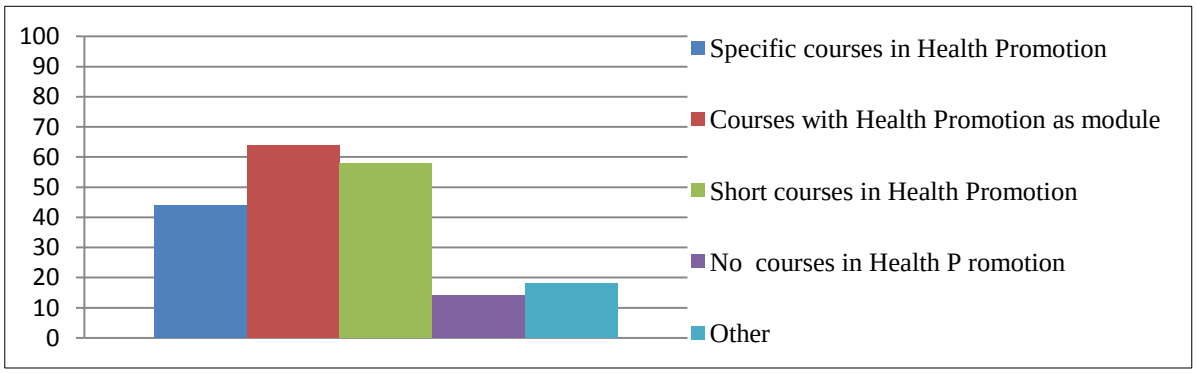

Figure 8 National Level Health Promotion Training and Education in country (Respondents could choose more than one option) N= 36

The types of education and training reported as currently available ranged from PhD programmes to local community training.[20]However, while the range of the education and training currently available was wide, most respondents (56%) considered that what was

[20] see Appendix 3 for full list

available was not adequate to build and maintain capacity for Health Promotion in their countries.

The Health Promotion education and training currently available was considered as being relevant and culturally appropriate to their country context by 74% of those responding. There were, however, some negative comments on the education and training available, for example:

> *'Most of the Health Promotion materials are an exact copy of translated materials that do not reflect local culture or even region or village-specific issues. In addition, activities are not innovative and are copied from each other.'*

The key drivers identified in relation to education and training in Health Promotion are listed in Table 2 and can be summarised as:

- Existing Education/Training Institutions
- Existing workforce/partners
- Demand for qualified health promoters
- Positive policy context

The major barriers to education and training in Health Promotion are detailed in Table 3 and can be summarised as issues related to:

- Job/employment availability
- Economic and social context
- Lack of understanding of Health Promotion/best practice
- Lack of courses and qualified teachers

Table 2 Drivers for education and training in Health Promotion

Existing Education/ Training Institutions	Demand for qualified health promoters	Policy/ HP Centre /Programmes	Existing partners/ workforce	Resources	Other
• Universities • Recently started bachelor degree • In - service training in Health Promotion for health care professionals.	• Demand for qualified health promoters by the government • Market forces for jobs and prevention strategies • Having specific position for Health Promotion in health system	• Epidemiological shift from Communicable to NCDs • National Health Policy • Republican Health Promotion Centre, • Appropriate policies • Government support for Health Promotion and Prevention. • Burden of chronic disease / national health agenda • Willingness of Ministries of Education and Health • The regional and country level favourable to Health Promotion	• Enthusiasm, professionalism and commitment of the participants, local government, broader community • Dedicated Health Promotion workforce • Dedicated work force, community support, organised NGO and youth groups, faith based groups. • Champions within civil society, for example, faith leaders	• Material resources both from within and outside the country • Availability of resources in local language	• Assorted media specially radio • Explaining the meaning of Health Promotion. • Develop new change agents in this area, / and awareness of people about HP • Medical statistics, social control, consumerism

Table 3 Barriers to education and training for Health Promotion

Job/profession related	Economic/Social Context	Problems with / lack of understanding of best practice	Lack of qualified teachers/ academic leadership/courses
• Lack of certification and jobs. dedicated for Health Promotion. • Recognition of human resource capacities. • Lack of clear job description • Health Promotion position in health system. • Low financial support of professionals in this field. • No jobs for Health Promotion. • Shortage of man power and transport to reach isolated communities. • No job placement for specialists. • Lack of government jobs. • Staff in Health Promotion need to (be) strengthened with Health Promotion qualifications and know how.	• The social context /economic difficulties limit development. • Lack of interest from political level. • At Governmental level priority is given to health policy / management not Health Promotion. • Lack of dedicated Health Promotion policy, low priority, inadequate. funding and poor visibility of Health Promotion .Not seen as a priority. • Lack of policy support. • Political priorities of the Ministry of Health and lack of finances. • Health Promotion is not given due recognition in the Government sectors, the most important sector for service provision. • Lack of funding support • The whole idea of Health Promotion is not present beyond the traditional contents of Public Health. • The system is curative or medical preventive biased. • Not perceived a priority by the population.	• Lack of conceptualisation of programmes and coordination of actions. • Traditional approach to HP, no established minimum standards, not standardised or context related. • Discontinuity in research capacity building; • Lack of evidence of good practices. • Lack of knowledge/ positive attitude towards health. • Misunderstanding about HP - everyone assumes the expert role no one understanding what it is about. • Fragmentation and minimal coordination /all wanting to be the leaders without collaborating or identifying focal measures to work on. • Biomedical vision of health professionals. Don't know what HP is all about. • No focus on sustainability. • Confusion: traditional public health, sanitarism, health education/HP • No understanding of HP or adopting its convenient bits.	• Lack of qualified teachers of HP. • Lack of participatory teacher training/ interdisciplinary orientation in education. • Few educational opportunities/ not given priority. • Absence of experienced teachers/ institutional conflicts of interest/ /understanding of academic leadership • Not enough competent training staff. • Lack of adequate budget for education/training • No Bursaries for HP employees. • Lack cooperation NGO's, Governmental and Academia. • Not enough relevant training courses on HP/education at various levels /undergraduate, postgraduate. • No curricula or guidelines. • Curriculum for Undergraduate programmes needs to be strengthened by practical components for experiential learning. • Because courses are not profitable few people can afford them

Competency frameworks and accreditation for Health Promotion

Less than a quarter of those responding (22%) indicated that there were competency frameworks for Health Promotion available in their country. Of the few existing frameworks one was developed as part of a World Bank project, while another was described as drawing on '*the Australian competencies, regional Guidelines (WHO/AFRO) and on the Galway Consensus Statement on Domains of Core Competencies for Health Promotion* .'

In a related finding, a majority of those responding (58%) rated formal accreditation for Health Promotion as being of high. or very high, importance.

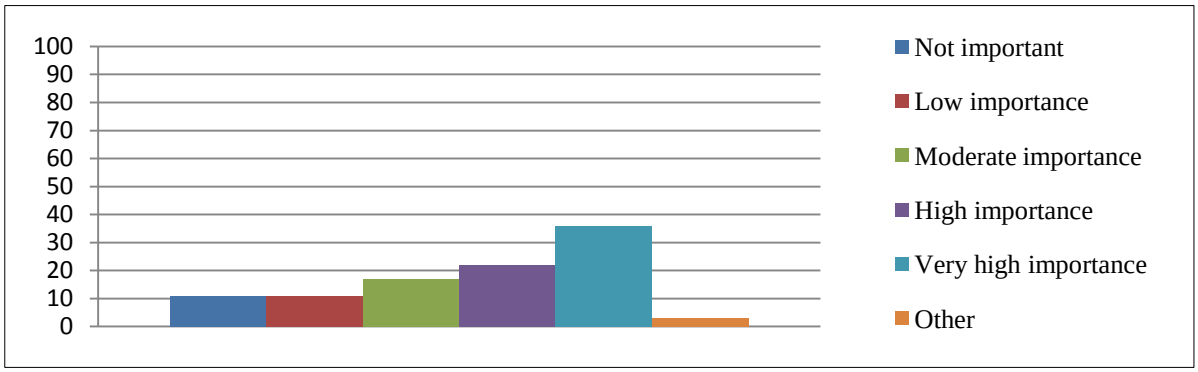

Figure 9 Opinions on importance of formal accreditation for Health Promotion training and education n=36

Training and education needs

Respondents were asked to rate their opinions on the importance of core competencies as identified in the Domains of Core Competencies in the Galway Conference Consensus Statement (16) in relation to education and training needs. Of these, 'enabling change' and 'knowledge competencies' were rated as the most important while 'assessment' received the lowest rating.

Competency	Rating average[21]
Enabling change	4.47
Leadership:	4.37
Assessment:	4.21
Planning	4.24
Implementation	4.42
Evaluation /Research	4.38
Advocacy	4.41
Partnership	4.35
Communication	4.32
Knowledge	4.44

Table 4 Opinions on priority education and training needs

[21] Rating levels 1-5 where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance 5 = very high importance

'Basic foundation level courses' and 'continuing professional development courses for Health Promotion practitioners ' were equally rated as being the most required types of education and training .

Type of course	Rating average[22]
Basic foundation level courses for health workers and other professionals	4.30
Continuing professional development courses for Health Promotion practitioners	4.30
Bachelor's level courses	3.73
Post graduate level courses (Master's, PhDs)	3.82
Advanced training /mentoring for retention of qualified Health Promotion staff	3.85

Table 5 Opinions on type of education /training needed

Health Promotion practitioners, followed by primary care professionals, were rated as the highest priority target groups for training and education. Health service managers and policy makers were equally rated as the target groups of least priority.

Priority target groups	Rating average[23]
Community workers	4.00
Primary health care professionals	4.38
Health Promotion practitioners	4.53
Other health service professionals (doctors, nurses, etc.)	3.91
Health service managers	3.79
Local government managers	3.91
Policy makers (e.g. Ministry of Health)	3.79
Educators (teachers in schools, colleges etc	4.03

Table 6 Opinions on priority targets for Health Promotion education and training

Face-to-face lectures and workshops were identified as the most useful methods of delivery for education and training for Health Promotion, while distance learning through online courses materials was the least favoured method.

Preferred methods of delivery	Rating average[24]
Lectures and workshops (face - to - face)	4.71
Distance education through online courses/material	2.44
Distance education through written courses/material	2.59
Blended delivery via face-to-face lectures and distance education	3.56
Mentoring	3.94

Table 7 Opinions on preferred methods of delivery of education and training on Health Promotion

[22] Rating range 1-5 where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance 5 = very high importance
[23] Rating range 1-5 where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance 5 = very high importance
[24] Rating range 1-5 where1 = least useful, 2 = somewhat useful, 3= moderately useful, 4= useful, 5 = most useful

Access to information on Health Promotion

The majority of those responding (71%) considered that those who undertake Health Promotion activities in their country did not have adequate access to information on Health Promotion. The main barrier to accessing information was identified as a lack of access to resources for travel to conferences, workshops, etc. The lack of availability of information in appropriate languages and/or which is relevant to cultural contexts was not generally perceived as a major barrier to accessing information by those responding to the survey.

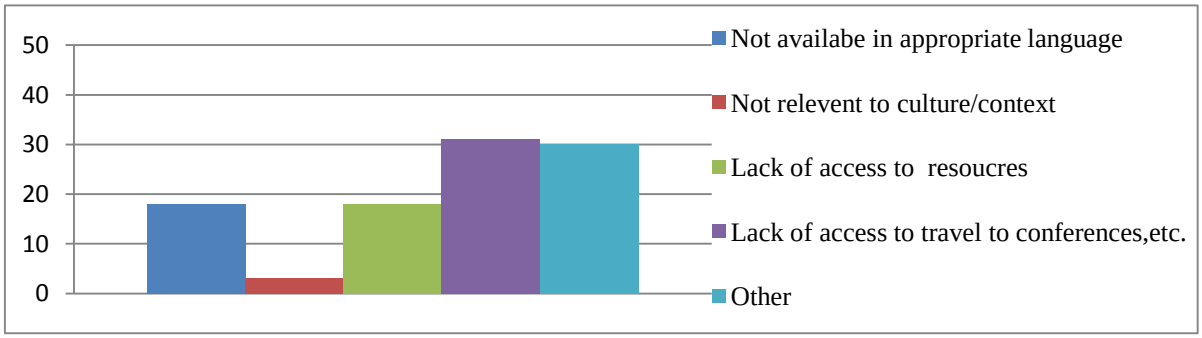

Figure 10 Opinions on barriers to accessing information N=33

Other comments on barriers to accessing information included reference to a lack of:

- access to resources such as books
- qualified teachers to teach the relevant skills
- easy access to internet use and resource libraries (particularly in rural areas).

Sharing information on Health Promotion was indicated as most frequently occurring at the national level but, it was stressed that were few opportunities for sharing information at any level.

Respondents' suggestions on how access to information could be improved are listed in Table 8 and can be summarised as:

- Local/national workshops and conferences
- Local/national networks forums/professional associations
- Journals/publication
- Access to resources/translations
- Education and training

Table 8 Suggestions on methods to increase sharing of information on Health Promotion

Workshops/conferences, etc	Networks/forums/ professional associations	Journals/publications Access to translation/ resources	Education	Other methods
• Workshops, national conferences. • Seminars, invite experts to address Health Promotion practitioners /other professionals. • Hold local and regional conferences to share lessons learnt. • National workshops on HP trainings at various levels. • More teleconferences to gain wider participation and not just a selected few. • Organise more meetings within country /participate in international or regional meetings. • Opportunities at the national level should be strengthened and there should be more people talking the same language.	• Developing formal networks within institutions /between institutions. • Strengthening the links and networks at all levels. • Through local points and networks. • Through networks, exchange programmes, organising different activities, meetings. • Activate work of Public Health association. • Forming of professional association specific to Health Promotion.	• Develop a journal at country and regional level. • Development of a national or regional resource data base and centres to provide access to Health Promotion resources/ alternatively work with institutional libraries to equip them with the necessary materials. • Waiving subscription fees on Health Promotion journals for middle and low income countries. • Translating information available on HP at international level. • International exchange of experience, access to international literature/material/courses/ communication.	• Academic courses, continuous education courses. • Academic degrees, funding, infrastructures and networking.	• Strengthening the level of collaboration between specialists. • Improving marketing about Health Promotion and courses. • Health Promotion needs evidence based to persuade people about its need. • Health Promotion should be first identified as a priority at the national level. • The need to address Health Promotion principles by the national authorities is a priority in exploring ways to share information. • Start with something basic first.

Existing strengths and assets in relation to capacity building for Health Promotion

Respondents viewed the 'strong leadership provided by key individuals and organisations', followed by 'commitment of the existing workforce' as the most important existing strength or asset for capacity building for Health Promotion in their country while links to regional and global networks were rated as the least important.

Strengths and assets	Rating average [25]
Community knowledge, tradition and culture	3.90
Eagerness to learn and to build capacity	3.70
Low cost infrastructure leading to more sustainable Health Promotion capacity building	3.69
Political commitment	3.65
Commitment of the existing workforce	4.00
Strong leadership provided by key individuals and organisations	4.45
Links to regional and global networks	3.37
Civil society partnerships (e.g., multiple levels of government, NGOs and community organisations)	3.90

Table 9 Opinions on most important existing strengths /assets in country in relation to capacity building for Health Promotion

The majority of respondents (61%) considered that there were examples of good practice in Health Promotion in their country, including:

- A Master's degree described as 'very well anchored in the African context'.
- Blended face-to-face and distance learning short course.
- Re-orientation of existing training programme of Health Education Officers to become Health Promotion Officers.
- Programmes at University level develop by national Schools of Public Health.
- Training of trainers for youth, teachers, volunteers, medical professionals.
- Youth friendly services, youth centres.
- IEC[26] campaign regarding TB prevention.
- Community Action for Health Programme.[27]
- Experiences of various NGOs in their areas of influence.
- Networks such as Health Promoting Schools and Health Promoting Universities (organised by AcDev[28]) and Workplace Health Promotion activities.

[25] Rating range 1-5 where ; 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:
[26] Information, Education and Communication
[27] http://www.cah.kg/en/home/
[28] http://www.acdev-int.com/

Perceived roles for regional and global networks in relation to capacity building for Health Promotion

The majority of those responding (69%) stated that they were not aware of regional or global networks to support education and training in Health Promotion in their country or region. This is an interesting finding given that the scoping study was lead by a major global network with an established role in this field and that this was clearly identified in all of the correspondence with respondents.

Those who could identify regional or global networks to support education and training in Health Promotion named the following:

- IUHPE
- ASPHER[29]
- Health Promotion Schools Network
- Refips (International Francophone Health Promotion Network)[30]
- Community Action for Health programme.
- WHO Country and Regional Offices
- Collaboration with other projects

Both ASPHER and the IUHPE were credited by one respondent as supporting education and training by creating unified standards for training.

The IUHPE was clearly identified as the organisation which should take a lead role in education and training for Health Promotion at regional and global levels, closely followed by the World Health Organisation.

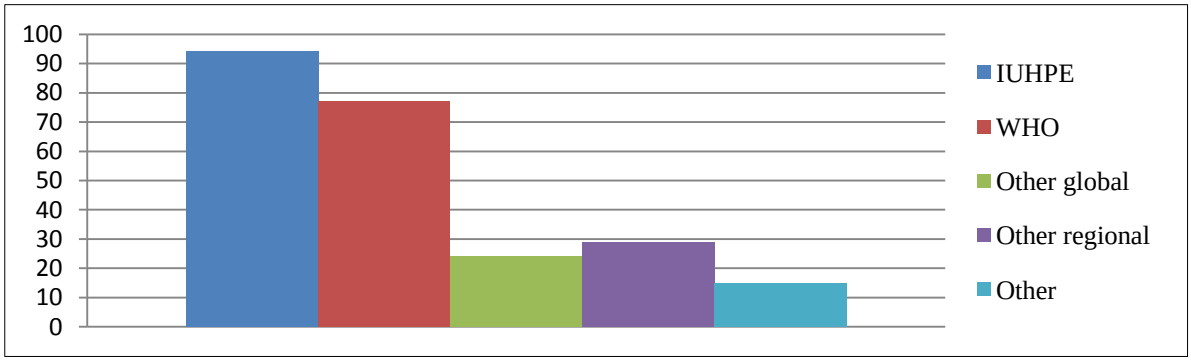

Figure 11 Opinions on which organisations should take a lead role in training and education for Health Promotion at global/regional levels (respondents could choose more than one option) N=34

The importance of partnerships between global, regional and local organisations when developing education and training for Health Promotion was stressed, with reference made to

[29] http://www.aspher.org/
[30] http://www.refips.org/

the need to include, for example, public and private schools, voluntary communities, Ministries of Health and Universities. It was also suggested that the IUHPE should provide funding to enable local organisations to take the lead role in developing education and training in their own area.

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

Priority activities	**Rating average** [31]
Lobbying for support for education and training	4.35
Providing resources	4.24
Developing short courses for delivery by local tutors	4.15
Running short courses including supplying lecturers/facilitators	4.42
Providing advanced training and mentoring	4.42
Accrediting local education and training courses	4.29
Providing criteria for core competencies and professional standards	4.47
Supporting the establishment of regional and national level training and education networks/forums	4.50

Table 10 Opinions on priority activities for lead organisations

Requests for assistance from the IUHPE

Few of those responding (24%) had requested assistance from the IUHPE in relation to training and education or other capacity development activities for Health Promotion. Some of those who had made such requests reported negative responses and, in one case, no response:

- *Requested videos on various lectures but was told to buy them.*
- *Asked for assistance to attend to the 20th IUHPE conference - it was denied.*
- *Enquired about membership to Journal but did not receive any reply.*

Others, however, reported more positive outcomes:

- *Got support during participation in the annual events of IUHPE Conferences.*
- *Foundation course, five weeks, for Health Promotion practitioners.*
- *Funding to participate in international conferences or workshops three times.*
- *Support from IUHPE for the HP short course and also the Master degree course Support gained via two members of the IUHPE and also documents and about US$6000 in 2009 for a short course.*

[31] Rating range 1-5 where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:

Additional Comments

The final question in the questionnaire asked respondents if they wished to make any additional comments and these are detailed in Table 11 and can be summarised as relating to:

- Training needs
- Constraints
- Support/resources needed
- Existing resources

Table 11 Respondents added the following comments to their responses to the questionnaire:

Training needs	Constraints	Support/resources needed	Existing resources	Other comments
• Need to train individuals at masters and PhD levels, run the training courses at national level. • The education in Health Promotion is by separate modules within postgraduate level programmes. We need advanced training for further development.	• After training most trained Health Promotion practitioners linger without employment in other provinces. • The current health policy of the new government has an approach to Health Promotion but in general health workers in the public system, municipalities and NGOs are not able to operationalise the policy. • The small number of the workforce needed for existing HP network is one of the most important risk factors for the development of any training programme. We do not have state support for training activities and people do not want to invest own money without seeing job possibilities.	• There is need to provide technical support to Health Promotion training as is a new field and we need to build the knowledge base for HP theory and practice. • We need more funding and capacity development opportunities in all levels. • School of Public is developing Health Promotion track for undergraduate training. Since Health Promotion is multidiscipline approach, our knowledge is limited. We need more training on HP in order to provide training and advocating for HP.	• We have many courses in different levels • Universities offer Masters degree / Bachelors degree. • Much experience in developing capacity for community capacity building. • Programmes but one which need to be reframed because mainly focused on health education.	• It is a priority and efforts should be made to strengthen the existing capacity and training programmes rather than creating new ones. • I believe consistency in communicating the Health Promotion concept is very important. • Capacity building would be better taken care of if we train people in country in order to train more and handpicked the best for specialist training.

Findings

Breakdown of responses across regions[32]

Response rate

The following comparisons are based on low response number (in some cases only two respondents) and so cannot be regarded as being statistically significant.

The response rate within regions was highest in EURO region (62%) and lowest in the ORLA region (17%).

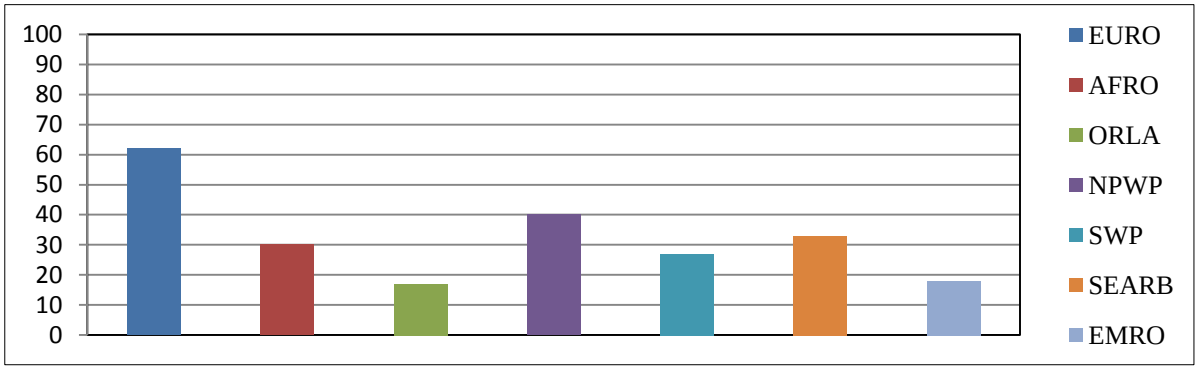

Figure 12 Response rates per region based on valid sample in each region

Terms used to describe health improvement activities

Health Promotion was the term most commonly used in the EURO, AFRO and SEARB regions, while the NPWP region reported that 'Health Promotion' was not used in any context.

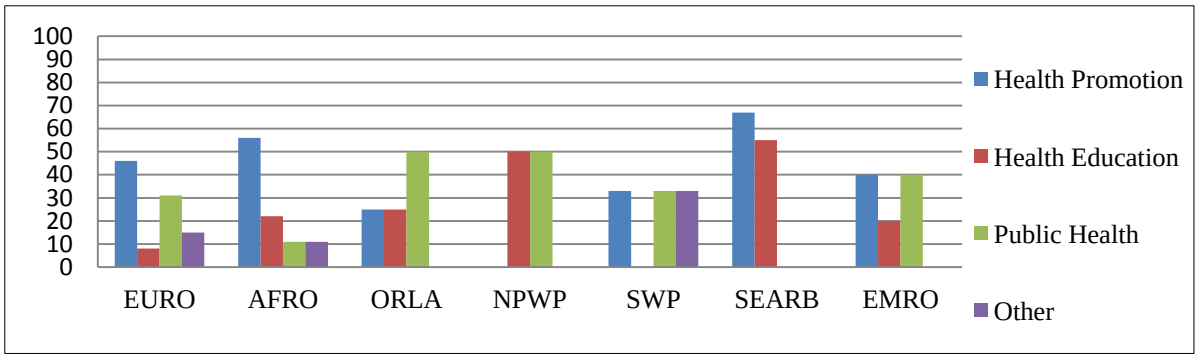

Figure 13 Term used to described Health Promotion activities by region

[32] The comparisons are based on low response number (in some cases only two respondents) and so cannot be regarded as being statistically significant.

Current capacity for Health Promotion - policies, posts and funding

Heath Promotion sections/units were reported as existing in all regions but with differences within regions.

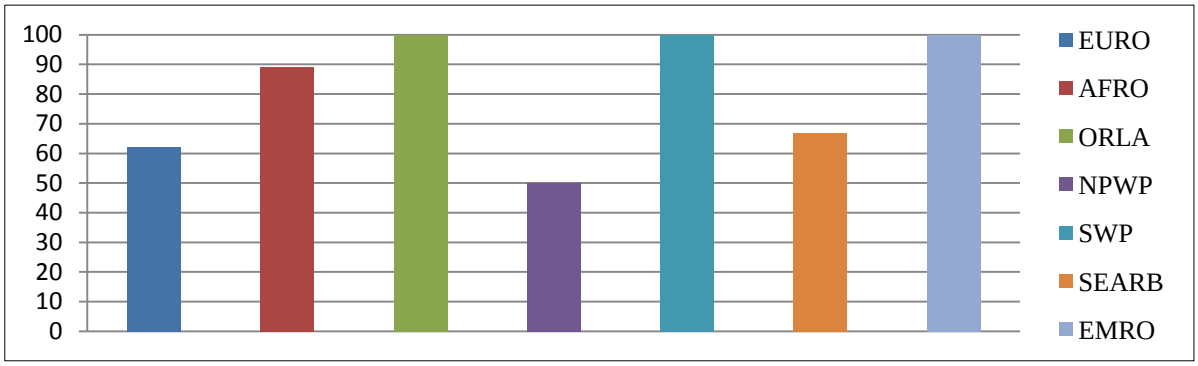

Figure 14 Percentage with identifiable Health Promotion unit/section within Ministry of Health by region

Some of the respondents in all regions, except the EMRO region, reported having posts/job descriptions with the title Health Promotion in their countries.

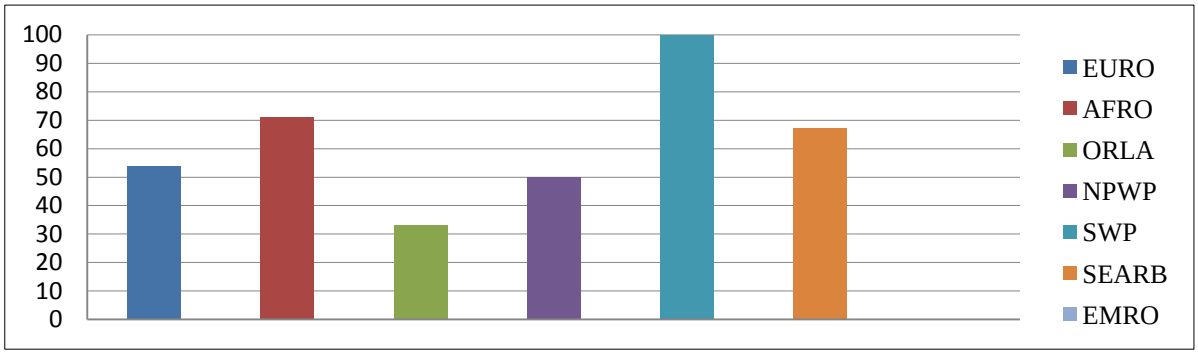

Figure 15Percentage dedicated posts/job descriptions with title Health Promotion

Respondents from all regions reported having Health Promotion policies or Health Promotion input into other policies, with total agreement in the EMRO region, but differences of opinion among respondents in other regions.

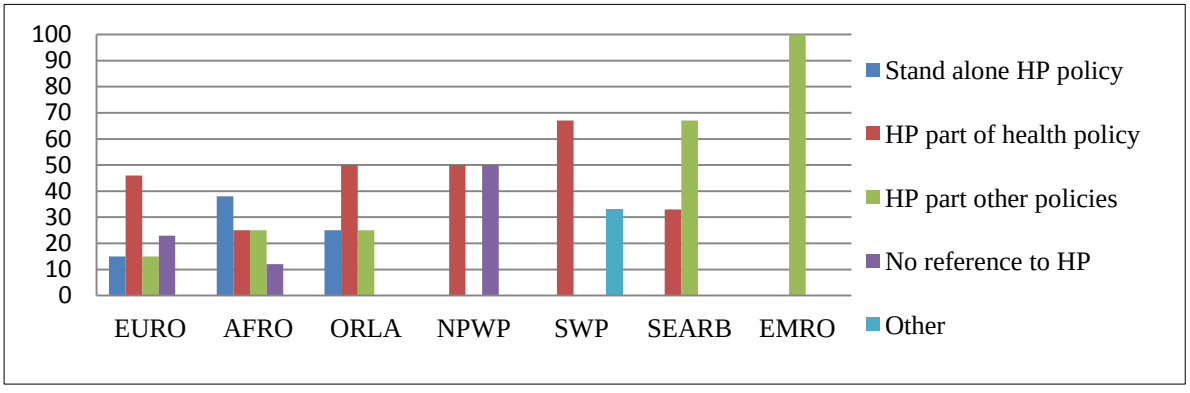

Figure 16 Health Promotion in policies by region

Governmental and nongovernmental funding was reported as being available for Health Promotion activities in all regions but with differences of opinions within the regions.

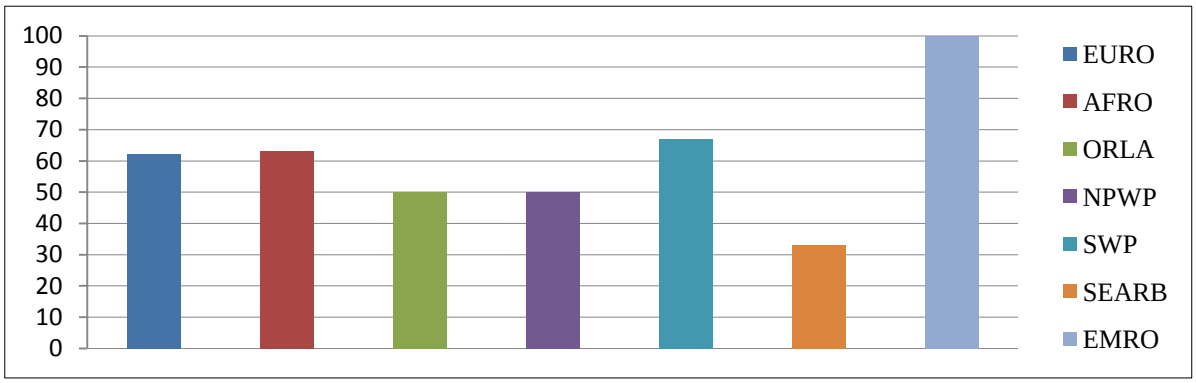

Figure 17 Percentage receiving governmental funding for Health Promotion activity by region

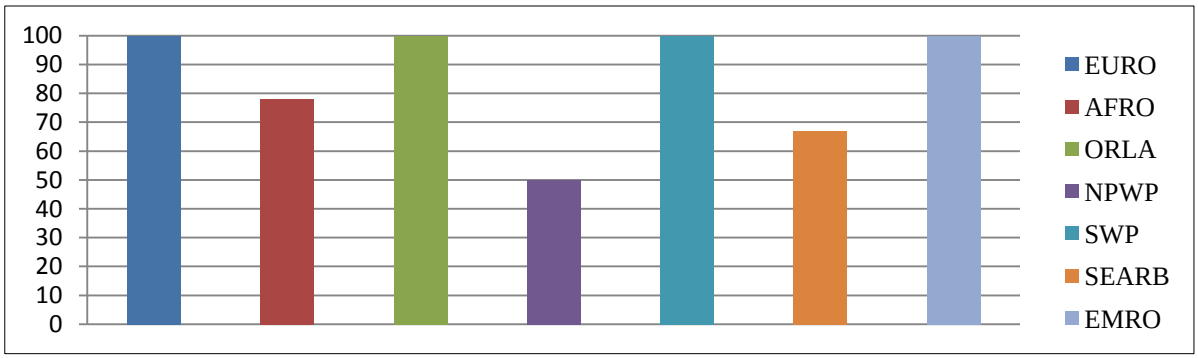

Figure 18 Availability of other sources of funding for Health Promotion activities by region

Health Promotion strategies employed

There were differences across the regions in the frequency of employment of the 'action areas' of the Ottawa Charter (33). For example, only respondents from the EURO region rated 'developing personal skills' as the most frequently employed action area (rated equally with 'building healthy public policy'). The NPWP was the only region where 'creating supportive environments' and 'reorientation the health service' were rated as most frequently employed (rated equally with 'building healthy public policy').

Action area	EURO	AFRO	ORLA	NPWP	SWP	SEARB	EMRO
Developing personal skills	2.50	2.50	2.25	1.50	3.00	3.33	2.50
Reorienting Health service	1.41	1.87	2.50	2.00	2.33	2.33	1.00
Creating supportive environments	2.16	2.22	2.25	2.00	3.33	2.16	2.00
Strengthening community action	2.41	3.00	2.25	1.50	4.00	2.66	3.00
Building healthy public policy	2.50	2.66	3.00	2.00	2.66	3.66	2.00

Table 12 Frequency of employment of Ottawa Charter areas[33]

[33] Rating range 1-4 where 1 = not employed, 2= infrequently employed 3 = frequently employed, 4= very frequently

Opinions on the need for a dedicated Health Promotion workforce with specialised training

Respondents in all regions clearly agreed that there was a need for a dedicated Health Promotion workforce with specialised training (EURO region 92%, AFRO region 90% and other regions 100%).

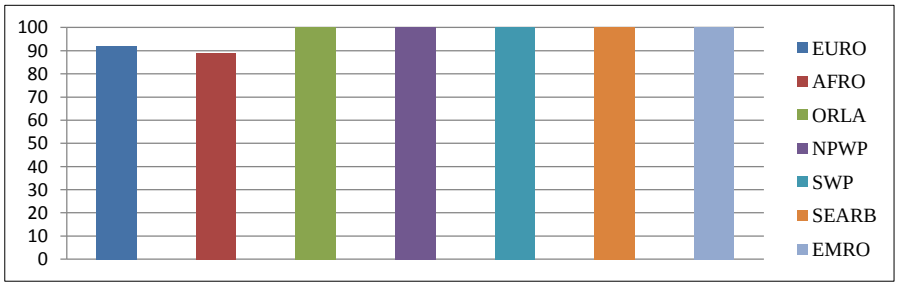

Figure 19 Need for dedicated Health Promotion workforce by region

Existing education and training

There were differences of opinion within regions on the availability of Health Promotion courses with some respondents in the EURO (15%), AFRO (10%) and EMRO regions (50%) indicating that there were no Health Promotion courses of any type in their country.

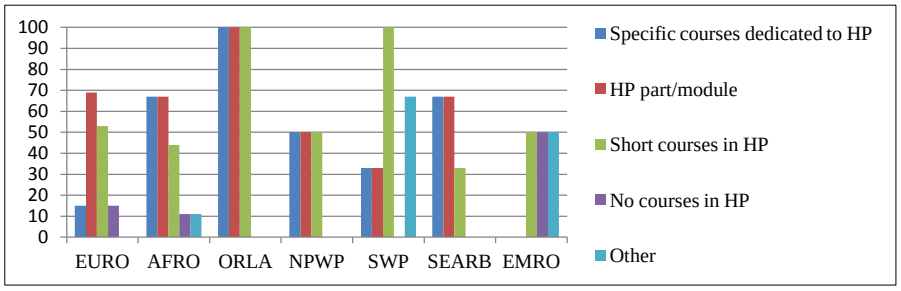

Figure 20 Existing education and training by region

The majority of respondents in all regions considered that the existing training and education for Health Promotion in their countries was not adequate to build and maintain workforce capacity.

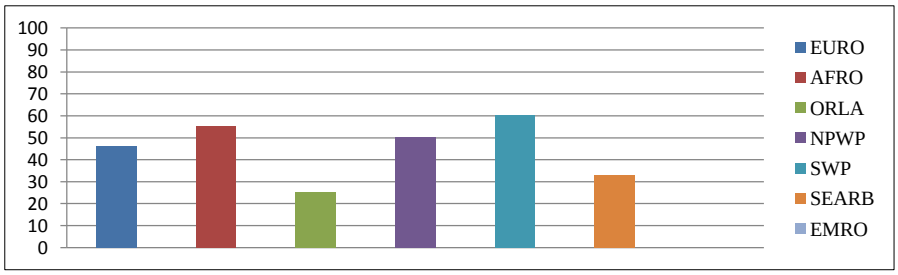

Figure 21 Opinions on adequacy of training/ education in Health Promotion to build/ maintain workforce capacity

The Health Promotion education and training currently available was considered relevant and culturally appropriate in the EURO (79%), AFRO (78%), ORLA (75%), SEARB (100%) and SWP (100%) regions while opinion in the NPWP region was split. In the EMRO region there was consensus that education and training was NOT relevant or culturally appropriate.

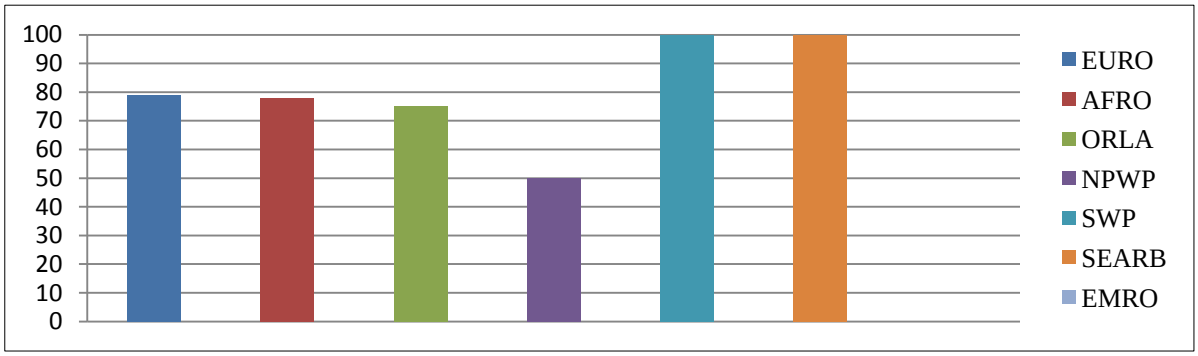

Figure 22 Opinions on relevance and culturally appropriateness of education and training by region

Competency frameworks and accreditation

The availability of agreed competency frameworks in Health Promotion was generally low with the SWP the only region with a significantly positive response (67%), followed by the AFRO (33%), the ORLA (25%) and the EURO (15%) regions while the NWPW, SEARB and EMRO regions indicated that no competency frameworks were available. Respondents in most of the regions indicated that accreditation of Health Promotion education and training was of high or very high importance.

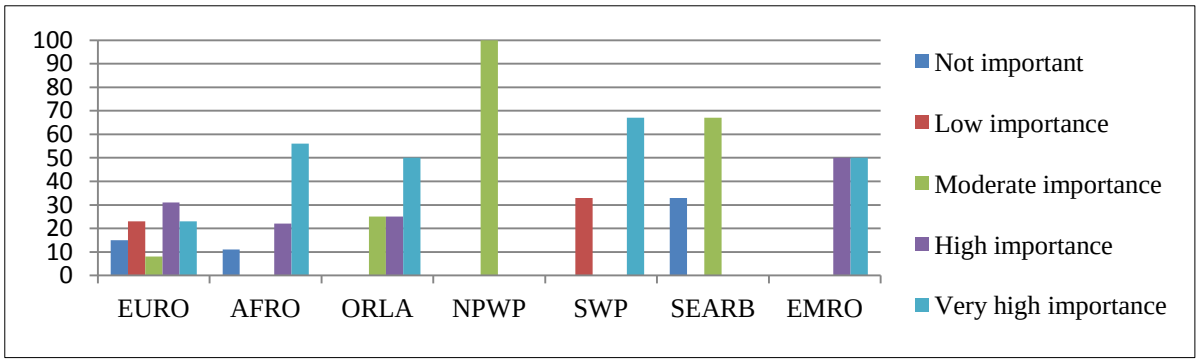

Figure 23 Opinions on importance of accreditation of training and education in Health Promotion by region

Training and education needs

There was no clear agreement across regions in relation to the most important training and education needs. However, 'Communication competencies' were not rated as most important by any region.

Competency	EURO	AFRO	ORLA	NPWP	SWP	SEARB	EMRO
Enabling change	4.30	5.00	4.25	3.50	3.66	4.50	4.00
Leadership:	4.15	4.75	4.00	3.00	5.00	5.00	4.50
Assessment:	3.75	4.85	3.50	4.50	4.66	4.50	4.50
Planning	3.92	4.85	3.50	4.50	4.33	5.00	4.50
Implementation	4.16	4.85	3.50	4.50	4.66	5.00	4.50
Evaluation /Research	4.33	4.85	4.00	3.00	5.00	5.00	4.00
Advocacy	4.38	5.00	3.75	4.00	4.33	4.50	4.00
Partnership	4.15	4.85	3.75	5.00	4.33	4.50	4.00
Communication	4.23	4.86	3.75	4.50	4.33	4.00	4.00
Knowledge	4.23	5.00	4.00	4.00	4.66	4.50	4.50

Table 13 Priority education and training needs based on Galway Consensus Statement core competencies[34]

There was also a range of opinions from respondents across the regions on the type of courses most required. In the EURO region prioritised postgraduate courses while Bachelor level courses were not identified as a priority by any region.

[34] Rating range 1-5 where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance 5 = very high importance

Type of course	EURO	AFRO	ORLA	NPWP	SWP	SEARB	EMRO
Basic foundation level courses for health workers and other professionals	3.60	4.44	4.25	5.00	4.33	4.00	5.00
Continuing professional development courses for Health Promotion practitioners	3.50	4.25	4.50	4.50	5.00	4.50	4.50
Bachelor's level courses	3.41	4.37	2.75	4.50	4.33	3.50	3.50
Post graduate level courses	3.83	4.37	4.00	3.00	4.33	3.00	3.50
Advanced training and mentoring for the retention of qualified Health Promotion staff	3.83	3.87	3.50	3.50	3.66	4.50	3.50

Table 14 Opinions on types of education and training needed[35]

There was some agreement across regions that Health Promotion practitioners were the priority target group for education and training. Health service professionals, health service managers and educators were not identified by any region as a priority target group while only the AFRO region identified policy makers as a priority target group.

Priority target groups	EURO	AFRO	ORLA	NPWP	SWP	SEARB	EMRO
Community workers	3.83	3.75	4.50	3.50	4.33	4.00	4.50
Primary health care professionals	4.38	4.25	4.25	5.00	4.66	4.50	4.00
Health Promotion practitioners	4.16	4.87	4.75	4.50	5.00	5.00	4.00
Other health service professionals (doctors, nurses, etc.)	3.58	4.50	3.75	3.50	4.00	4.00	4.00
Health service managers	3.58	4.37	3.00	4.00	4.00	4.00	3.50
Local government managers	3.83	4.00	3.50	4.00	4.00	3.50	4.50
Policy makers (e.g. Ministries)	4.23	4.87	4.25	4.00	4.00	4.50	4.00
Educators (schools, colleges, etc.)	4.00	4.16	4.40	4.50	4.33	3.00	4.00

Table 15 Opinions on priority target groups for training and education

There was clear agreement across all regions that face-to-face lectures and workshops were the preferred methods of delivery for education and training. There was some variation in opinions, although with overall low ratings, in relation to online courses, an interesting finding given the emphasis on this method of delivery in the literature.

[35] Rating range 1-5 where1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance

Preferred methods of delivery	EURO	AFRO	ORLA	NPWP	SWP	SEARB	EMRO
Lectures and workshops (face - to - face)	4.61	4.50	4.75	5.00	5.00	5.00	5.00
Distance education through online courses/material	2.38	2.75	2.75	1.50	1.00	1.50	2.00
Distance education through written courses/material	2.38	3.12	2.75	1.50	1.00	1.50	2.00
Blended delivery via face-to-face lectures and distance education	3.69	4.00	3.25	2.00	4.00	2.50	3.50
Mentoring	3.75	4.00	3.50	2.00	4.66	4.00	4.50

Table 16 Opinions on the preferred methods of delivery of education and training[36]

Respondents in the ORLA and SWP regions had the most positive opinions on the appropriateness of the focus of activities for Health Promotion within their countries (67%) while those from the AFRO and SEARB regions indicated the lowest rating at 33% in each.

Access to information on Health Promotion

Respondents from most regions considered that those who undertake Health Promotion activities in their countries did not have adequate access to information. The SWP region had the most positive result (67%) to the question, with all in the SEARB region considering that access to information was NOT adequate.

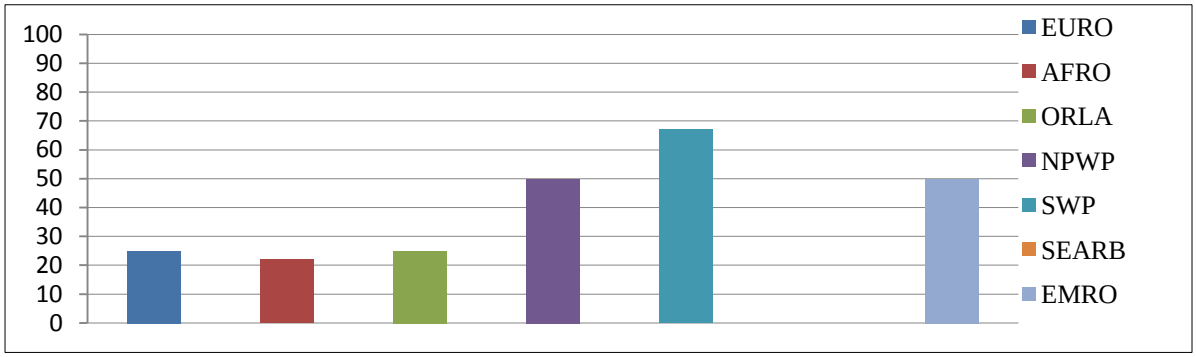

Figure 24 Adequacy of access to information for those who undertake Health Promotion activities by region

The barriers to accessing information on Health Promotion varied across the regions, with only one respondent (in the EMRO region) identifying a lack of culturally appropriate information.

[36] Rating range 1-5 where1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance

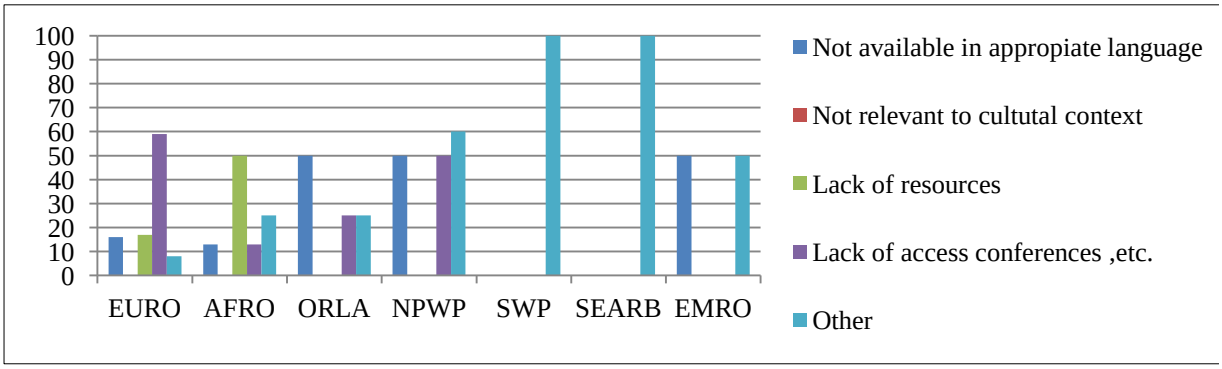

Figure 25 Barriers to accessing information by region

Respondents in most of the regions considered that opportunities for sharing information on Health Promotion occurred at all the levels indicated, with differences within and between regions.

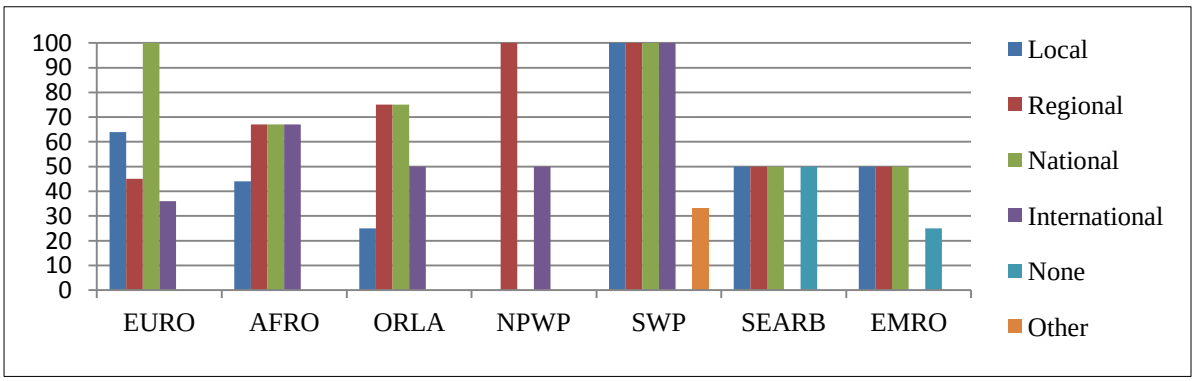

Figure 26 Opinions opportunities for sharing information on Health Promotion on different levels by region (respondents could choose more than one option)

Existing strengths and assets in relation to capacity building for Health Promotion

There were differences of opinion on the most important existing asset or strength for capacity development, although the AFRO, ORLA and SWP regions agreed on 'community knowledge, tradition and culture'. 'Eagerness to learn and to build capacity' was not rated as most important by any region.

Strengths and assets	)	AFRO	ORLA	NPWP	SWP	SEARB	EMRO
Community knowledge, tradition and culture	3.45	4.42	4.66	4.00	5.00	2.50	3.00
Eagerness to learn / build capacity	3.60	4.28	3.00	3.00	3.00	3.50	3.00
Low cost infrastructure /more sustainable capacity building	3.54	4.33	2.66	4.00	3.66	4.50	3.00
Political commitment	3.45	3.50	3.50	4.50	3.50	4.50	4.00
Commitment of existing workforce	4.18	4.42	3.25	4.00	4.50	4.00	3.50
Strong leadership by key individuals /organisations.	3.63	4.25	3.00	3.50	4.00	3.50	4.50
Links to regional / global networks	3.27	4.00	2.66	2.50	3.33	3.50	3.50
Civil society partnerships (e.g. NGOs, government, community)	3.63	4.33	3.25	4.50	4.33	4.50	3.50

Table 17 Opinions on most important existing strengths /assets in country for capacity building for Health Promotion[37]

In the ORLA, SWP and EMRO regions opinions were unanimous that there were examples of good practice in Health Promotion in their countries, followed by the AFRO (67%), EURO (50%) regions. Those from the NPWP, and SEARB regions reported that they could not identify examples of good practice in their countries.

Awareness of and roles for regional and global networks for capacity building for Health Promotion

All respondents in the ORLA and SEARB regions indicated that they were not aware of global networks which supported education and training in Health Promotion. The SWP region recorded highest awareness of such networks (62%), followed by the NPWP and EMRO (50%), EURO (36%) and AFRO (22%) regions.

Respondents in all regions rated the IUHPE as either the most appropriate organisation, or in the case of the NPWP, SEARB and EMRO regions, the most appropriate jointly with the WHO, to take the lead role in developing education and training in Health Promotion.

[37] Rating range 1 -5 where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:

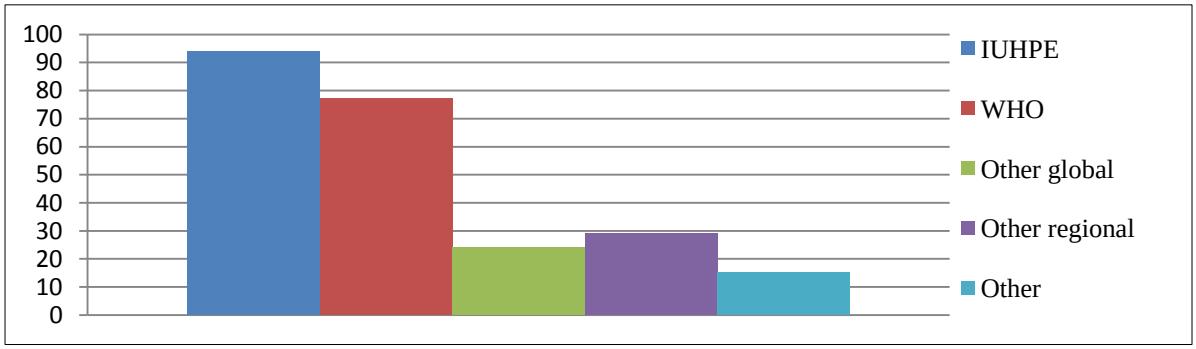

Figure 27 Opinions on which organisations should take a lead role in training and education for Health Promotion at global/regional levels (respondents could choose more than one option) N=34

Opinions varied across the regions on the priority actions which should be taken by a lead organisation in relation to capacity development for Health Promotion.

Priority activities	EURO	AFRO	ORLA	NPWP	SWP	SEARB	EMRO
Lobbying for support for education and training	4.33	4.11	4.25	4.50	4.33	5.00	3.00
Providing resources	4.08	4.44	4.50	3.00	4.66	4.50	4.00
Developing short courses for delivery by local tutors	4.16	4.37	4.50	4.50	5.00	5.00	5.00
Running short courses including supplying lecturers	4.16	4.37	4.25	4.00	5.00	4.00	4.50
Providing advanced training and mentoring	4.41	4.75	4.00	4.00	4.66	4.50	4.00
Accrediting local education a	3.75	4.88	4.25	4.00	4.33	4.50	4.00
Providing criteria for core competencies / professional standards	4.25	4.77	3.80	3.50	4.66	4.00	5.00
Supporting the establishment of regional / national training and education networks/forums	4.33	4.87	4.33	3.50	4.00	4.50	5.00

Table 18 Opinions on priority activities for organisations[38]

Requests for assistance for capacity development from the IUHPE

Some respondents from all regions, except the NPWP and SEARB regions had requested assistance for support for education and training or other capacity development activity from the IUHPE (SWP and AFRO, 33%, and EURO and ORLA, 25%). A more detailed analysis of the requests received by the IUHPE over the past five years was planned as part of this study but it proved difficult to access information on this within the available timescale.

[38] Rating range 1-5 where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:

DISCUSSION AND CONCLUSIONS

This scoping study attempted to explore current capacity for Health Promotion and training and education needs in LAMICs globally. The study, although limited by a low response rate, provides some insight into the levels of capacity for Health Promotion in LAMICs and the views of the Health Promotion community on education and training needs in the designated IUHPE regions.

The low response rate was not unexpected given the low response rates recorded for online surveys, the size and diversity of the target audience, and the fact that the questionnaire was available in English only. It also proved difficult to identify relevant contacts with a recognised role in Health Promotion despite support from the IUHPE Regional Vice Presidents and access to IUHPE membership lists. Some of these difficulties relate to the fact that there are a limited number of practitioners with Health Promotion as their formal job title. For the purpose of future research and capacity development activities it would be useful if each IUHPE Region had available, not only lists of members' names, but also their profiles and those of others active in Health Promotion, who could act as champions and facilitators to widen the scope of information gathering and sharing.

A major barrier to achieving a better response rate was, undoubtedly, language and future efforts in scoping capacity at a global level should be undertaken in at least Spanish and French, which, together with English, are the official languages of the IUHPE.

The low response rate means that it is impossible to draw any firm conclusions, especially with regard to any differences in findings between the IUHPE regions. Therefore, a key issue for further research in this field is to increase the reach of such studies and ensure a more representative sample with a better response rate.

However, despite the difficulties recognised in relation to online surveys, they provide a useful and feasible method to use when attempting to reach a wide and diverse audience at a global level and are likely to remain the tool of choice in global studies. More preparation of the target audience before sending the online questionnaire may be useful in future related research, for example, through a preparatory article in IUHPE publications, introductory emails or letters from Regional Vice Presidents and a link from the IUHPE website to the data collection point.

In spite of the low response rate, the findings of the scoping study as a whole provide a 'snap shot' of the current capacity for Health Promotion and views on the training and education needed to maintain and further build that capacity in the IUHPE regions. The opinions of the respondents on the roles which the IUHPE can play to support capacity development also provide a useful basis for future IUHPE strategies.

Such strategies can build on the fact that the need for an informed and strategic approach to the development of the Health Promotion workforce is well established. There is a wealth of resources on capacity development and workforce capacity development in particular, to inform the development of future strategies. It is suggested that an overarching focus of such strategies should be to inform, educate, and promote debate and research on the best approaches to Health Promotion workforce development at local, regional, national and international levels.

Shared terminology and understandings of key concepts are of utmost importance when exploring and developing Health Promotion workforce capacity globally. In this study, Health Promotion was identified as the term most commonly used for health improvement activities but with some differences across regions and language groups. However there was reference to a lack of clarity about what was meant by Health Promotion and confusion about differences between Health Promotion, Public Health and Health Education. This finding highlights the difficulties of attempting to deal with the complex concept of Health Promotion when addressing multilingual, multicultural audiences. There is a need to agree and disseminate definitions and understandings of Health Promotion so that all involved in workforce capacity development have a shared terminology, ethical framework and understanding of core concepts and principles. The development of core competencies is a practical way to progress this shared understanding and to establish a quality basis for workforce capacity development. The development of core competencies can in itself help develop capacity, if it uses consensus building approaches as is the case in the CompHP Project[39] which aims to develop competencies, professional standards and an accreditation system for Health Promotion in Europe.

While it was reported that there was an identifiable Health Promotion unit or section within Ministries of Health in the majority of countries and in all regions, a smaller number indicated the existence of dedicated posts/job descriptions with the explicit term 'Health Promotion'.

[39] http://www.iuhpe.org/index.html?page=614&lang=en

This begs the question ‘who is engaged in Health Promotion activities in the dedicated units’? There were references to the need for ‘standalone’ Health Promotion units as the basis for quality practice and as drivers for further capacity development but also reference to the recent closing of one such unit due to a lack of resources. The need to advocate for national centres of excellence for Health Promotion has previously been identified by the IUHPE and it is obvious that in a negative economic climate, this advocacy role is more important than ever.

A key issue for all aspects of capacity development in Health Promotion, including workforce development, is the availability of sufficient and sustained funding. Funding from governmental and nongovernmental sources for Health Promotion was reported as being available in the majority of countries responding but there was a lack of clarity about how much was actually available and the amounts differed across the regions. Overall, irrespective of source, funding was described as small or limited, project specific and not sustained.

The lack of sustained funding (and action) was also noted as a specific barrier to workforce capacity development. In developing a strategic approach to supporting capacity development globally, the issue of sustainability - both of funding and of action - must be a key factor. In relation to funding and particularly nongovernmental funding, the focus of IUHPE action should be on raising the profile of Health Promotion as a valid capacity development approach with the major funding development agencies globally.

The concept of Health Promotion as a development activity is reinforced by the finding that, in relation to the strategies employed to implement Health Promotion, ‘strengthening community development’ was the Ottawa Charter action area reported as being most frequently employed. However, the barriers to capacity development identified included reference to a continuing emphasis on the biomedical approach and ‘traditional’ approaches to Health Promotion.

There were differences across the regions in the Ottawa Charter actions areas most frequently employed. Future research on capacity development should include interviews with key informants in the regions to identify the factors influencing the choices made in relation to ‘action areas’ and the impact of this on forward planning. This, and other differences across regions, also points to the need to take account of local and regional contexts and avoid a ‘one size fits all’ approach in any aspect of capacity development.

Overall, the focus of Health Promotion activities in the countries responding was considered as not being appropriate for best practice. The downturn in the world economy was considered to

be further limiting the quest for best practice as it meant limited resources for Health Promotion and an increased emphasis on acute care. The negative impact of the global economic crisis means that more than ever there is a need for strong advocacy for Health Promotion at all levels - a key role for the IUHPE. Evidence of the effectiveness of Health Promotion is of particular relevance at this time of economic scarcity and future strategies should build on existing evidence and include reference to developing and disseminating more evidence of effectiveness.

The evidence of effectiveness can, for example, be a major argument for the development of a Health Promotion workforce with specialised training. A large majority of respondents were in favour of such a workforce and considered that this was required to improve practice and limit the use of 'inappropriate approaches'. For some few countries, however, a dedicated workforce was considered to be an unrealistic target as there was no demand for, or resources to sustain, such a workforce. While the development of a dedicated workforce is obviously strongly supported by those active in Health Promotion, questions about the likelihood of such a workforce growing in the current economic climate, given the fact that this has remained an aspiration only even in more stable economic periods, must be considered by the IUHPE in prioritising its key action areas.

The strong support for a dedicated workforce should also be considered in the context of the barriers identified to capacity development, including a lack of certification/accreditation and clear job descriptions for Health Promotion. Current education and training available was rated as currently not being adequate to build and maintain Health Promotion capacity in most countries, a finding which would indicate that there will be a need to develop many more education and training programmes if there is to be an increase in the numbers of a dedicated workforce with specialised training. Given that a lack of academic leadership and qualified teachers and a lack of funding for training and education were identified as barriers to developing training and education, future IUHPE strategies will need to explore the most effective interventions to address the gap and increase the numbers of a dedicated Health Promotion workforce.

Also linked to the positive response to developing a specialised workforce is the finding that formal accreditation for Health Promotion was rated as being of high or very high importance by over half the respondents. Despite this support for accreditation, less than a quarter of those responding had access to competency frameworks which could form the basis for accreditation. Developing agreed competencies could address many of the barriers to capacity development

identified in the study, including the lack of recognised qualifications, accreditation and job descriptions. Developing competencies and professional standards was also identified as a priority focus for a lead organisation at global level with a remit for capacity development. The Galway Conference Consensus Statement on the Domains of Core Competencies at global level and the emerging competencies, standards and accreditation system being developed at the European level[40], can inform further development of agreed competencies for Health Promotion at global level.

Most respondents in most countries reported the existence of some form of education and training in Health Promotion, although this was not the case in five countries with programmes ranging from PhD level to community training. The list of education and training providers identified by respondents, together with a list of Health Promotion resources which form part of this report, provides a useful starting point for a global directory of Health Promotion courses. This directory could be developed by the Regional Vice Presidents and made accessible on the IUHPE website. The directory could be the starting point for sharing of information, resources and possibly educators and students, given the necessary funding.

It is interesting to note that most respondents considered that the education and training available to them was relevant and culturally appropriate. This finding was reinforced by responses which indicated that lack of availability of information in an appropriate language or which was relevant to cultural contexts was not generally perceived as a barrier to accessing information on Health Promotion. These findings in relation to language may, however, be influenced by the fact that the questionnaire was in English only. In relation to cultural appropriateness this finding should also be viewed cautiously as there were differences across the regions with some clear indications that for some the training and education available was not relevant and/or culturally appropriate. Those respondents who did consider that there were problems in relation to language and culturally relevance expressed their opinions and dissatisfaction very strongly.

The training and education needs identified as being of most importance were ‘enabling change’ and ‘knowledge competencies’. ‘Enabling change’ is key to strengthening community action, which was the Ottawa Charter action area identified as most frequently employed. The identification of the knowledge base for Health Promotion as one of the most important areas for training and education can be linked to comments on the lack of clarity about what

[40] CompHP Project

constitutes Health Promotion and misunderstandings about what it entails in practice. Differences in the needs identified as being the most important across the regions will need to be considered when developing global strategies to avoid a 'one size fits all' approach.

'Basic foundation courses in Health Promotion' and 'Continuing Professional Development' were identified as the types of training and education most required overall. The key target group identified for training and education was Health Promotion practitioners which relates well with the CPD finding, but less so with that of basic foundation courses. The most favoured method of delivery for training and education was face-to-face lectures, with distance learning delivered online as the least favoured method and these findings were constant across all regions. Given the resource implication of face-to-face training and education, particularly in countries with a large geographic spread and limited resources, some investigation of why people are reluctant to engage in online learning would be useful. If it is the case that there is no or limited access to the internet then obviously online approaches are unrealistic. However, it may be that some 'capacity development' in the form of training in computer skills before starting the Health Promotion elements of an online course would be a constructive way to deal with any lack of confidence or competence about online learning. There is a growing literature on best practice for online delivery of education and training and it would be useful if resources on best practice were to be made accessible on the IUHPE website as part of a capacity development strategy.

The negative reaction to online delivery of education and training is also relevant to IUHPE strategies to support access to information on Health Promotion. Current access to information on Health Promotion by those undertaking health improvement activities was not considered to be adequate by respondents in all the countries responding. The main barrier to accessing information was identified as a lack of resources to travel to conferences, meetings, etc. The finding that respondents were reluctant to use online courses would appear to negate what could otherwise seem to be a good solution to this, namely e-conferences. Again, despite the negative reaction to online engagement, it is suggested that e-conferencing be further explored as a means of sharing information on Health Promotion. There are ever more interactive programmes for e-meetings and e-conferences which may help overcome the apparent resistance to online interaction and communication. Building partnerships with other capacity development agencies in the regions to explore and develop IT media suitable for and accessible to, the regional, national and local Health Promotion community would allow for economies of scale in information sharing.

Other suggestions for improving access to information offered by respondents included establishing regional and national level training and education networks/forums networks and support for the development of professional associations as useful ways of supporting improved information sharing. Given the regional structure of the IUHPE it is suggested that each Regional Vice President be asked to undertake a review of how best to support access to information in their regions and to develop a strategy to take this forward within the context of a global strategy.

Most respondents considered that there were examples of good practice in their countries which they could share as part of regional and global information sharing initiatives, including a range of educational courses. Providing a forum, both globally and within regions, which facilitate sharing of these examples of good practice, would support capacity development within countries and regions. It may also be possible to establish regional support networks for practitioners to develop reports on their examples of good practice into articles for peer reviewed journals. It would also be useful to get regional practitioners to become involved in the peer reviewing process, particularly in areas where they have particular expertise. However, there is also a need for less formal information sharing, for example, on a regional IUHPE webpage, which could have links to various regional and local projects, networks and information.

The potential role of the IUHPE at a regional level is clearly highlighted in undertaking information sharing and other capacity development activities. Despite the fact that this study was undertaken by the IUHPE and that this was clearly identified in the information sent out with the questionnaire, most respondents stated that they were not aware of global networks which support capacity building for Health Promotion. However, the IUHPE was identified by the majority of respondents as the organisation that should take a lead role in education and training for Health Promotion, closely followed by the World Health Organisation. Whichever organisation is to take the lead on capacity development for Health Promotion, it was suggested that this role should be developed in partnership with local and regional networks.

It is interesting to note, therefore, that 'supporting the establishment of regional and national level training and education networks/forums' was identified as the priority activity which should be undertaken by the lead organisation at global level. These networks/forums could be the key to many of the capacity development suggestions made in the responses to the study. These findings, together with the need to recognise local needs and assets when undertaking capacity development, reinforce the continuation of a decentralised model for the

IUHPE. A major task for the IUHPE at regional level is to develop and maintain information on relevant networks and work in partnership with them to develop shared action on capacity development. The IUHPE at global level could focus on well developed mechanisms for sharing information on a regular and coordinated basis and on some core foundations for all capacity development work, for example, the development of agreed gore competencies at global level. This is supported by the fact that 'Providing criteria for core competencies and professional standards' was the second priority activity identified for a lead organisation.

In relation to requesting support from the IUHPE, very few of those who responded to the questionnaire had done so. Those who had reported mixed responses, with some having received support and others indicating that they did not. It would be useful if there it was clearly stated in IUHPE strategies and on the website what it is able to provide in relation to support for capacity development, for example, provision of information, contacts regarding courses, trainers, etc. together with clear criteria for accessing any available support. This would make for a more transparent and accountable system Records of all requests and how they were processed should be kept as these would be useful for further exploration and evaluation of capacity development activities and members' expectations of support.

The findings of this scoping study, while somewhat limited by a low response rate, indicate useful points for consideration by the IUHPE when developing a strategic approach to workforce capacity development for Health Promotion. There is, for example, clear indication of support for a dedicated workforce with specialised training but also of limited and unsustained funding and few active practitioners with Health Promotion in their job title or description. Health Promotion units and departments are under pressure and, in at least one case a 'standalone' unit has recently closed down.

A workforce capacity development strategy will also need to identify at what levels, and by what means, the IUHPE can best contribute to such development, including widening its role from training and education to encompass other capacity development roles. Additional roles could include:

- increased and more focused advocacy for Health Promotion as a core element of broader capacity development action
- developing and supporting partnerships and networks at regional and international levels
- developing criteria for competencies, standards and accreditation for Health Promotion to assure quality globally.

Recommendations

Specific recommendations relevant to the work of the IUHPE in developing workforce capacity for Health Promotion include:

- Use the terms 'capacity development/workforce development' in future work and strategies.
- Agree the specific priority target groups for future strategies, e.g. 'countries with identified capacity needs/LAMICs', etc.
- Undertake a stakeholder analysis of key country contacts across the different IUHPE regions.
- Agree the priorities for IUHPE action in relation to capacity development for Health Promotion given the multilevel approaches identified in the literature and limited resources based on the priority areas identified in the study.
- Focus strategies on the priority areas identified for action in this study
    - *Supporting the establishment of regional and national level training and education networks/forums*
    - *Providing criteria for core competencies and professional standards building on the Galway Consensus Statement and the experience of the CompHP Project in Europe.*
- Clarify and develop the respective roles of the central and regional elements of the IUHPE in supporting the establishment of regional and national level training and education networks/forums.
- Clarify the role of the IUHPE in supporting capacity development, e.g. as a provider of support/information/resources, together with explicit criteria for applications,
- Record all requests for assistance and support on any capacity development activities, together with details of any action taken,
- Include awareness raising and training on the concepts of capacity development in its broadest sense and workforce capacity development as part of future strategies.
- Consider the feasibility of supporting the development of a dedicated workforce with specialist training as a major focus of IUHPE capacity development strategies in the current economic context.
- Explore the potential of using the Internet in capacity development activities. This should include, but not be limited to, online courses, online mentoring, e-conferences and meetings.
- Explore the potential of working in partnership with other development agencies in developing and maintaining suitable and accessible IT technologies to support all aspects of capacity development.
- Target advocacy for sustainable funding of Health Promotion as a priority within major global capacity development organisations and funding bodies, not limited to those with a remit for health.
- Make contact with organisations such as the Global Health Alliance as a potential partner in global capacity development for Health Promotion.

- Explore opportunities to work with and influence other capacity development organisations and funders not limited to those engaged in health work in relation to Health Promotion as a core development approach.
- Agree a model for mapping existing Health Promotion capacity at different levels and for evaluating progress. This should be developed in the context of mapping models used in other capacity development fields and in partnership with relevant capacity development organisations.
- Establish a dedicated website (perhaps in partnership with other organisations such as the WHO) which provides information on existing education and training and supports practitioners in making links and share information.
- Develop a brokerage system for capacity development initiatives such as mentoring (to include online methods), exchanges of students and workplace experience.

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APPENDICES

Appendix 1

List of Low and middle income countries World Bank (3)

Countries reported as having low, low middle and upper middle economic income. Countries where contacts were identified for the study are highlighted.

Country	IUHPE Region	Geographic region	Income level
Afghanistan		South Asia	Low income
Albania	EURO	Europe & Central Asia	Lower middle income
Algeria	AFRO	Middle East & North Africa	Upper middle income
American Samoa	SWP	East Asia & Pacific	Upper middle income
Angola	AFRO	Sub-Saharan Africa	Lower middle income
Argentina	ORLA	Latin America & Caribbean	Upper middle income
Armenia	EURO	Europe & Central Asia	Lower middle income
Azerbaijan	EURO	Europe & Central Asia	Lower middle income
Bangladesh	SEARB	South Asia	Low income
Belarus	EURO	Europe & Central Asia	Upper middle income
Belize	ORLA	Latin America & Caribbean	Lower middle income
Benin	AFRO	Sub-Saharan Africa	Low income
Bhutan	SEARB	South Asia	Lower middle income
Bolivia	ORLA	Latin America & Caribbean	Lower middle income
Bosnia and Herzegovina	EURO	Europe & Central Asia	Upper middle income
Botswana	AFRO	Sub-Saharan Africa	Upper middle income
Brazil	ORLA	Latin America & Caribbean	Upper middle income
Bulgaria	EURO	Europe & Central Asia	Upper middle income
Burkina Faso	AFRO	Sub-Saharan Africa	Low income
Burundi	AFRO	Sub-Saharan Africa	Low income
Cambodia	NPWP	East Asia & Pacific	Low income
Cameroon	AFRO	Sub-Saharan Africa	Lower middle income
Cape Verde	AFRO	Sub-Saharan Africa	Lower middle income
Central African Republic	AFRO	Sub-Saharan Africa	Low income
Chad	AFRO	Sub-Saharan Africa	Low income
Chile	ORLA	Latin America & Caribbean	Upper middle income
China	NPWP	East Asia & Pacific	Lower middle income
Colombia	ORLA	Latin America & Caribbean	Upper middle income
Comoros	AFRO	Sub-Saharan Africa	Low income

Congo, Dem. Rep.	AFRO	Sub-Saharan Africa	Low income
Congo, Rep.	AFRO	Sub-Saharan Africa	Lower middle income
Costa Rica	ORLA	Latin America & Caribbean	Upper middle income
Côte d'Ivoire	AFRO	Sub-Saharan Africa	Lower middle income
Cuba	ORLA	Latin America & Caribbean	Upper middle income
Djibouti	EMRO	Middle East & North Africa	Lower middle income
Dominica	ORLA	Latin America & Caribbean	Upper middle income
Dominican Republic	ORLA	Latin America & Caribbean	Upper middle income
Ecuador	ORLA	Latin America & Caribbean	Lower middle income
Egypt, Arab Rep.	EMRO	Middle East & North Africa	Lower middle income
El Salvador	ORLA	Latin America & Caribbean	Lower middle income
Eritrea	AFRO	Sub-Saharan Africa	Low income
Ethiopia	AFRO	Sub-Saharan Africa	Low income
Fiji	SWP	East Asia & Pacific	Upper middle income
Gabon	AFRO	Sub-Saharan Africa	Upper middle income
Gambia, The	AFRO	Sub-Saharan Africa	Low income
Georgia	EURO	Europe & Central Asia	Lower middle income
Ghana	AFRO	Sub-Saharan Africa	Low income
Grenada	ORLA	Latin America & Caribbean	Upper middle income
Guatemala	ORLA	Latin America & Caribbean	Lower middle income
Guinea	AFRO	Sub-Saharan Africa	Low income
Guinea-Bissau	AFRO	Sub-Saharan Africa	Low income
Guyana	ORLA	Latin America & Caribbean	Lower middle income
Haiti	ORLA	Latin America & Caribbean	Low income
Honduras	ORLA	Latin America & Caribbean	Lower middle income
India	SEARB	South Asia	Lower middle income
Indonesia	SEARB	East Asia & Pacific	Lower middle income
Iran, Islamic Rep.	EMRO	Middle East & North Africa	Lower middle income
Iraq	EMRO	Middle East & North Africa	Lower middle income
Jamaica	ORLA	Latin America & Caribbean	Upper middle income
Jordan	EMRO	Middle East & North Africa	Lower middle income
Kazakhstan	EURO	Europe & Central Asia	Upper middle income
Kenya	AFRO	Sub-Saharan Africa	Low income
Kiribati	WP	East Asia & Pacific	Lower middle income
Korea, Dem. Rep.	NPWP	East Asia & Pacific	Low income
Kosovo	EURO	Europe & Central Asia	Lower middle income
Kyrgyz Republic	EURO	Europe & Central Asia	Low income
Lao PDR	NPWP	East Asia & Pacific	Low income
Latvia	EURO	Europe & Central Asia	Upper middle income
Lebanon	EMRO	Middle East & North Africa	Upper middle income

Lesotho	AFRO	Sub-Saharan Africa	Lower middle income
Liberia	AFRO	Sub-Saharan Africa	Low income
Libya	EMRO	Middle East & North Africa	Upper middle income
Lithuania	EURO	Europe & Central Asia	Upper middle income
Macedonia, FYR	EURO	Europe & Central Asia	Upper middle income
Madagascar	AFRO	Sub-Saharan Africa	Low income
Malawi	AFRO	Sub-Saharan Africa	Low income
Malaysia	NPWP	East Asia & Pacific	Upper middle income
Maldives	SEARB	South Asia	Lower middle income
Mali	AFRO	Sub-Saharan Africa	Low income
Marshall Islands	SWP	East Asia & Pacific	Lower middle income
Mauritania	AFRO	Sub-Saharan Africa	Low income
Mauritius	AFRO	Sub-Saharan Africa	Upper middle income
Mayotte	AFRO	Sub-Saharan Africa	Upper middle income
Mexico	ORLA	Latin America & Caribbean	Upper middle income
Micronesia, Fed. Sts.	SWP	East Asia & Pacific	Lower middle income
Moldova	EURO	Europe & Central Asia	Lower middle income
Mongolia	NPWP	East Asia & Pacific	Lower middle income
Montenegro	EURO	Europe & Central Asia	Upper middle income
Morocco	EMRO	Middle East & North Africa	Lower middle income
Mozambique	AFRO	Sub-Saharan Africa	Low income
Myanmar	SEARB	East Asia & Pacific	Low income
Namibia	AFRO	Sub-Saharan Africa	Upper middle income
Nepal	SEARB	South Asia	Low income
New Caledonia	SWP	..	High income: non OECD
Nicaragua	ORLA	Latin America & Caribbean	Lower middle income
Niger	AFRO	Sub-Saharan Africa	Low income
Nigeria	AFRO	Sub-Saharan Africa	Lower middle income
Pakistan	EMRO	South Asia	Lower middle income
Palau	SEARB	East Asia & Pacific	Upper middle income
Panama	ORLA	Latin America & Caribbean	Upper middle income
Papua New Guinea	SWP	East Asia & Pacific	Lower middle income
Paraguay	ORLA	Latin America & Caribbean	Lower middle income
Peru	ORLA	Latin America & Caribbean	Upper middle income
Philippines	SWP	East Asia & Pacific	Lower middle income
Poland	EURO	Europe & Central Asia	Upper middle income
Romania	EURO	Europe & Central Asia	Upper middle income
Russian Federation	EURO	Europe & Central Asia	Upper middle income
Rwanda	AFRO	Sub-Saharan Africa	Low income
Samoa	SWP	East Asia & Pacific	Lower middle income

São Tomé and Principe	AFRO	Sub-Saharan Africa	Lower middle income
Senegal	AFRO	Sub-Saharan Africa	Low income
Serbia	EURO	Europe & Central Asia	Upper middle income
Seychelles	AFRO	Sub-Saharan Africa	Upper middle income
Sierra Leone	AFRO	Sub-Saharan Africa	Low income
Solomon Islands	SWP	East Asia & Pacific	Lower middle income
Somalia	AFRO	Sub-Saharan Africa	Low income
South Africa	AFRO	Sub-Saharan Africa	Upper middle income
Sri Lanka	SEARB	South Asia	Lower middle income
St. Kitts and Nevis	ORLA	Latin America & Caribbean	Upper middle income
St. Lucia	ORLA	Latin America & Caribbean	Upper middle income
St. Vincent and the Grenadines	ORLA	Latin America & Caribbean	Upper middle income
Sudan	AFRO	Sub-Saharan Africa	Lower middle income
Suriname	ORLA	Latin America & Caribbean	Upper middle income
Swaziland	AFRO	Sub-Saharan Africa	Lower middle income
Syrian Arab Republic	EMRO	Middle East & North Africa	Lower middle income
Tajikistan	EURO	Europe & Central Asia	Low income
Tanzania	AFRO	Sub-Saharan Africa	Low income
Thailand	SEARB	East Asia & Pacific	Lower middle income
Timor-Leste	SEARB	East Asia & Pacific	Lower middle income
Togo	AFRO	Sub-Saharan Africa	Low income
Tonga	SWP	East Asia & Pacific	Lower middle income
Tunisia	EMRO	Middle East & North Africa	Lower middle income
Turkey	EURO	Europe & Central Asia	Upper middle income
Turkmenistan	EURO	Europe & Central Asia	Lower middle income
Uganda	AFRO	Sub-Saharan Africa	Low income
Ukraine	EURO	Europe & Central Asia	Lower middle income
Uruguay	ORLA	Latin America & Caribbean	Upper middle income
Uzbekistan	EURO	Europe & Central Asia	Low income
Vanuatu	WP	East Asia & Pacific	Lower middle income
Venezuela, RB	ORLA	Latin America & Caribbean	Upper middle income
Vietnam	NPWP	East Asia & Pacific	Low income
West Bank and Gaza (Palestine)	EMRO	Middle East & North Africa	Lower middle income
Yemen, Rep.	EMRO	Middle East & North Africa	Low income
Zambia	AFRO	Sub-Saharan Africa	Low income
Zimbabwe	AFRO	Sub-Saharan Africa	Low income

Appendix 2

Questionnaire - Word document version.

1. Please complete the following details Name, Country, Job title Email
Organisation name, Organisation type (e.g. Academic, statutory body, NGO, etc.)

2. What term is most commonly used in your country for activities to improve health? Please choose one response by placing X in appropriate box

Health Promotion	
Health Education	
Public Health	
Other	

If other, please specify

3. Is there an identifiable 'Health Promotion' unit/section/department within the Ministry of Health or a group described differently but with similar explicitly stated functions in your country? *Yes ( ) No ( ) If yes, please provide the name and reference or web link.*

4. Are there dedicated posts or job descriptions, which contain the title 'Health Promotion' in your country? *Yes ( ) No ( ) If yes, please give details of range posts – e.g. statutory, NGO/ Other*

5. Is Health Promotion reflected in national government policies including health policy in your country? Please choose one response by placing X in appropriate box.

Yes, there is stand-alone Health Promotion policy	
Yes, Health Promotion is part of an overall health policy	
Yes, there are Health Promotion elements in policies other than health policy	
No, there is no reference to Health Promotion in health policies	
No information available	
Don't know	
Other	

If other, please specify

6. Is there dedicated governmental funding for Health Promotion activity in your country? *Yes ( ) No ( ) If yes, please specify annual amount and government department which is source of funding.*

7. Are other sources of funding available for Health Promotion activity in your country? *Yes ( ) No ( ) If yes, please give details of source of funding (e.g. NGOs, international donors, etc.) and annual amount*

8. In relation to strategies that are employed to promote health in your country, please indicate what is the main focus of Health Promotion activity by placing X in the appropriate box for each option where 1 = not employed, 2= infrequently employed 3 = frequently employed, 4= very frequently employed

	1	2	3	4
(A) Developing personal skills				
(B) Reorienting the health service				
(C) Creating supportive environments				
(D) Strengthening community action				
(E) Building healthy public policy				

Please add any comments:

9. Do you consider that the main focus of Health Promotion activity is appropriate for best practice in your country? *Yes ( ) No ( ) if f no, please indicate what you would consider to be more appropriate?*

10. In your opinion, is there is a need for a dedicated Health Promotion workforce with specialised training in your country? *Yes ( ) No ( ) If no, please explain why*

11. Are there any national-level education and training programmes in Health Promotion available in your country? You may choose more than one response. Please place X in appropriate boxes

Yes, there are specific courses (postgraduate Diploma and Master's courses or undergraduate Bachelor training) dedicated to Health Promotion	
Yes, there are courses in which Health Promotion is a module, a subject or a part	
Yes, there are short courses in Health Promotion for health and community workers (e.g. nurses, community workers, teachers, health professionals etc.)	
No, there is no specific training in Health Promotion	
No information available	
Don't know	
Other If other, please specify	

12. Please provide details of the main providers of education and training programmes in Health Promotion (if any) in your country. Please list name, organisation, web link, if any, and any other relevant information

13. Do you consider that the education and training available in your country is adequate to build and maintain workforce capacity for Health Promotion? *Yes ( ) No ( )*

14. Do you consider that the education and training in Health Promotion available in your country is relevant and culturally appropriate? *Yes ( ) No ( ) If no, please give details*

15. What do you see as the main drivers for education and training in Health Promotion in your country?

16. What do you see as the main barriers to education and training in Health Promotion in your country?

17. Are there any agreed competency frameworks or standards for Health Promotion practice in your country? *Yes ( ) No ( ) If yes, please give details*

18. In your opinion, how important is formal accreditation of education and training in Health Promotion in your country? Please choose one response by placing X in appropriate box.

Not important	
Low importance	
Moderate importance	
High importance	
Very high important	
Other	

If other, please give details

19. Please indicate what you consider to be the priority education and training needs in relation to Health Promotion skills and competencies in your country. Please rate the needs in order of priority by placing X in the appropriate box where 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance 5 = very high importance

	1	2	3	4	5
(A) Enabling change: Enabling change and empowering individuals and communities to improve their health.					
(B) Leadership: Contribute to the provision of strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for Health Promotion, supporting Health Promotion programmes and building capacity.					
(C) Assessment: Conducting assessment of needs and assets in settings and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental, organisational and political determinants that promote or compromise health.					
(D) Planning Developing measurable Health Promotion goals and objectives in response to assessment of needs and assets and identifying strategies that are based on knowledge derived from theory, evidence, and practice.					
(E) Implementation: Carrying out effective and efficient, culturally sensitive, and ethical Health Promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources.					
(F) Evaluation and Research: Determining the reach, effectiveness and impact of Health Promotion programmes and policies. This includes utilising appropriate evaluation and research methods to support programme improvements, sustainability, and dissemination.					
(G) Advocacy: Advocating with and on behalf of individuals and communities to improve their health and well-being and building their capacity for undertaking actions that can both improve health and strengthen community assets.					
(H) Partnership: Work collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of Health Promotion programmes and policies.					
(1)Communication: Communicating Health Promotion activities and programmes effectively using appropriate methods for diverse audiences					
(J) Knowledge: Demonstrating understanding of, and the ability to apply in practice, the theory, research and ethical dimensions of Health Promotion and the multidisciplinary knowledge base which underpins the competencies listed above.					

Other, please list any other competencies you consider most relevant – use additional page at end if necessary

20. In your opinion, what level of Health Promotion education and training is most required in your country? Please indicate the order of importance by placing X in the appropriate box; 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:

	1	2	3	4	5
(A) Basic foundation level courses in Health Promotion for health workers and other professionals					
(B) Continuing professional development courses for Health Promotion practitioners					
(C) Graduate level (bachelor's training) courses in Health Promotion					
(D) Graduate level courses (Master's, PhDs) in Health Promotion					
(E) Advanced training and mentoring for the retention of qualified Health Promotion staff					
Other					

If other, please specify

21. Who, in your opinion, is the priority target audience for training and education in Health Promotion in your country? Please indicate the choice in order of importance by placing X in the appropriate box; 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:

(A) Community workers	1	2	3	4	5
(B) Primary health care professionals					
(C) Health Promotion practitioners					
(D) Other health service professionals (doctors, nurses, etc.)					
(E) Health service managers					
(F) Local government managers					
(G) Policy makers (e.g. Ministry of Health)					
(H) Educators (teachers in schools, colleges etc.)					
i) Other If other, please specify					

22. What methods of delivery do you consider most useful for Health Promotion education and training in your country? Please indicate your choice in order of priority by placing X in appropriate box; 1 = least useful, 2 = somewhat useful, 3= moderately useful, 4= useful, 5 = most useful

	1	2	3	4	5
(A) Lectures and workshops (face-to -face)					
(B) Distance education through online courses/material					
(C) Distance education through written courses/material					
(D) Blended delivery via face-to-face lectures and distance education					
(E) Mentoring					

Other (please specify)

23. Do you consider that those who undertake Health Promotion activities in your country have adequate access to information on Health Promotion (i.e. theory, models, research, examples of best practice, etc?)

Yes ( ) No ( ) If yes, please describe the main sources of information. If no, please describe the main sources of information that are needed.

24. What, if any, is the main barrier to accessing information on Health Promotion in your country? Please choose one response by placing X in appropriate box.

Information not available in appropriate language	
Information not relevant to cultural context	
Lack of access to resources such as books, journals, databases etc.	
Lack of resources for travelling to conferences, workshops etc.	
Other (please specify)	

25. Please indicate what opportunities for sharing information on Health Promotion are available at all or any of the levels below. Please provide details, choosing more than one option if necessary: Local ( ) Regional ( ) National ( ) International ( ) None ( ) Other (please specify)
26. How would you suggest improving opportunities for sharing Health Promotion information, skills and experience at any level?

27. What do you consider to be the most important assets or strengths of your country in relation to building capacity for Health Promotion? Please indicate the choice in order of importance by placing X in the appropriate box; 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:

	1	2	3	4	5
(A) Community knowledge, tradition and culture					
(B) Eagerness to learn and to build capacity					
(C) Low cost infrastructure leading to more sustainable Health Promotion capacity building					
(D) Political commitment					
(E) Commitment of the existing workforce					
(F) Strong leadership provided by key individuals and organisations					
(G) Links to regional and global networks (					
(H) Civil society partnerships (e.g., multiple levels of government, NGOs and community organisations)					
Other					

If other, please specify

28. Are there examples of good practice in relation to training and education in Health Promotion in your country, which you consider would be useful to other countries*?*
Yes ( ) No ( ) If yes, please give details and suggest the best methods for sharing such resources

29. Are you aware of any networks which support education and training in Health Promotion in your country and/or region? *Yes ( ) No ( ) If yes, please give details*

30. What organisations, in your opinion, should take a lead role in developing and delivering training and education in Health Promotion at regional/global levels? You may choose more than one option. Please place X in appropriate boxes *If other, please specify*

International Union for Health Promotion and Education (IUHPE)	
World Health Organisation	
Other global organisation	
Other regional organisation	
Other	

31. In your opinion, what are the priority areas the organisation(s) you have identified above should focus on in relation to Health Promotion education and training for low and middle income countries? Please indicate the choice by placing X in the appropriate box; 1 = not important, 2 = low importance, 3= moderate importance, 4= high importance, 5 = very high importance:

	1	2	3	4	5
(A) Lobbying for support for education and training with national/regional governments					
(B) Providing resources e.g. written and online materials					
(C) Developing short courses for delivery by local tutors/facilitators					
(D) Running short courses including supplying lecturers/facilitators					
(E) Providing advanced training and mentoring for the retention and further development of trained Health Promotion staff					
(F) Accrediting local education and training courses (any level)					
(G) Providing criteria for core competencies and professional standards to guide the development of local education and training courses					
(H) Supporting the establishment of regional and national level training and education networks and forums					
Other If other, please give details					

32. Have you ever requested assistance from the IUHPE in relation to education and training? Yes ( ) No ( ) If yes, Please give brief outline of the assistance requested and the outcomes of this request.

33. Please comment on any other aspect of Health Promotion workforce capacity building, training and education in your country or other countries in your region of which you have knowledge. Please continue on additional page if necessary
Thank you for completing the questionnaire

Appendix 3

List of Training and Education facilitated identified by respondents

REGION	COUNTRY	ORGANISATION	WEBSITE
EURO	Kosovo	Department of Social Medicine, National Institute of Public Health of Kosovo, Medical Faculty, University of Pristine	
	Kyrgyzstan	Republican Centre for Health Promotion.	www.cah.kg
	Latvia	Faculty of Public Health of Riga, Stradins University	www.rsu.lv
	Lithuania	Public Health Institute Vilnius University	www.mf.vu.lt
	Romania	National Scholl for Public Health and Health Service Management (NSPHHSM) Public Health Departments, Medicine Universities	http://en.snspms.ro http://www.univermed-cdgm.ro/?pid=123
	Ukraine	School of Public Health	http://www.sph.ukma.kiev.ua/?&language=eng
ORLA	Brazil	Masters of Health Promotion University of Franca	www.promocaodesaude.unifran.br
	Cuba	Maestría en Promoción y Educación para la Salud de la ENSAP	www.ensap.sld.cu.
	El Salvador	Universidad José Simeón Cañas, Dpto de Salud Pública, Facultad de Medicina, Universidad de El Salvador	http://www.uca.edu.sv/ http://academica.fmoues.edu.sv/cambiacarr.html
	Mexico	Universidad Autonoma Methropolitana Xochimilco Universidad de la Ciudad de Mexico, Instito de Salud Publica	www.xoc.uan.mx,
AFRO	Regional	Agence de Medicin Preventive (AMP), for the central and western francophone countries	www.aamp.org,
	Regional	African Medical and Research Foundation AMREF an international African organisation headquartered in Kenya	http://www.amref.org/
	Kenya	Moi University Kenyatta University	http://www.mu.ac.ke/, http://www.ku.ac.ke/
	Mali	Faculty of Medicine - University of Mali	
	NGOs	Kara Counselling Chikankata Salvation Army Mission	http://www.kara.org.zm/ http://www1.salvationarmy.org/chikankata
	Senegal	Aced	http://www.acdev-int.org
	South Africa	University of Limpopo Turfloop Campus Walter Sisulu University University of Witwaterstrand University of the Western Cape	www.ul.ac.za www wsu.ac.za www .wits.ac.za www.uwc.ac.za
	Tanzania	Tanzania Primary Health care Institute	www.phci.ac.tz
	Uganda	Uganda Martyrs University	http://www.fiuc.org/umu/
	Zambia	University of Zambia	http://www.unza.zm/
	Zimbabwe	University of Zimbabwe	www.uz.ac.zw
WP (All)	Fiji	School of Medicine for Academic Program MOH for in-service and community based organisations	http://www.fsm.ac.fj/ http://www.health.gov.fj/
	Vietnam	Department of Health Promotion, Hanoi School of Public Health	www.hsph.edu.vn
SEARB	Sri Lanka	Department of Health Promotion, Wayamba University	http://www.wyb.ac.lk/
EMRO	Jordan	World Health Organisation Jordan Country Office	http://www.emro.who.int/jordan/

Appendix 4

List of Health Promotion Education and Training Resources (4)

Health Promotion Education & Training Resources	
	GLOBAL
Name	**PROLEAD**
Type	National leadership and management in health promotion (Country team projects)
Organisation	WPRO
Funding	WHO
Partners	World Health Organization Center for Health Development (WHO Kobe Center), Health Promotion Switzerland, International Network of Health Promotion Foundations, Southeast Asian Ministers of Education Organization Regional Tropical Medicine and Public Health Network (SEAMEO TROPMED), Thai Health Promotion Foundation (ThaiHealth), The Victorian Health Promotion Foundation (VicHealth), United Nations Environment Program (UNEP), Environmentally Sound Technologies Information System (ESTIS)
Region/Country	WPR/Global
Duration	Varies
Language/s	English
Brief	The course aims to develop leaders in health promotion, who apply their knowledge and skills to focus on and, develop projects attuned to local needs, with an understanding of global driving forces, and having the skills with which to implement these projects. Fellows are selected through the country offices of WHO, in collaboration with national governments.
Distance learning	Mix of online interaction and workshops oriented learning
Accreditation status	
Country projects till date	PROLEAD 1 (2004-2005): China, Malaysia, Mongolia, Philippines, Tonga PROLEAD II (2005-2006): India, Japan, Lebanon, Oman, Korea, Vietnam, SEAMO PROLEADPLUS (2007-2008): Brunei Darussalam, Cambodia, Fiji, Cook Islands, Kiribati, Lao PDR, Papua New Guinea, Samoa, Solomon Islands, Tonga, Vanuatu, Viet Nam GCC (GULF COOPERATION COUNCIL) PROLEAD (2007): Bahrain, Oman, Qatar, Saudi Arabia, Tunisia, United Arab Emirates, Yemen
Link	http://www.prolead.org/index.html
Address	Health Promotion Unit, Manila, Philippines Telephone: +632 528 8001 email: hpr@wpro.who.int or contact the WHO Country Office
Name	**Urban HEART**
Type	Urban Health Equity Assessment and Response Tool, a guide for policy- and decision-makers at national and local levels
Overview	Tool intended to give policy-makers and key stakeholders at national and local levels a user-friendly guide to assess and respond to urban health inequities. One of the responses to the assessment is to develop strategies to build capacity and competence in assessing the health equity impact of development projects.

Organisation	Kobe Center in partnership with WHO regional offices
Country / Region	Global
Language/s	English
Link	http://www.who.or.jp/urbanheart.html
Contact	1-5-1 Wakinohama-Kaigandori Chuo-ku, Kobe 651-0073 Japan Tel: (+81) 78-230-3100 Fax: (+81) 78-230-3178 email: wkc@wkc.who.int
Name	**Global Device on Social Determinants of Health and Public Policy Formulation**
Type	Self-instructional course on social determinants of health
Overview	Module targeted at WHO/PAHO staff members as well as Health Ministries' officials in all countries who are engaged in designing action programs, policies and plans for SDH. Aims to generate, disseminate and increase knowledge and facilitate the development of professional qualifications for applying SDH approach to public policies and other strategies via personal and institutional capacity-building processes.
Organisation	WHO
Country / Region	PAHO
Language/s	English, Spanish. Portuguese
Duration	Self learning, no time limit
Mode of Study	Self instructional, online
Accreditation	Participants receive a certificate after passing an electronically administered final exam.
Link	http://dds-dispositivoglobal.ops.org.ar/curso/cursoeng/contexto.html
Contact	The Partnership for Maternal, Newborn & Child Health World Health Organization 20 Avenue Appia CH-1211 Geneva 27, Switzerland Fax: + 41 22 791 5854 Telephone: + 41 22 791 2595
Name	**Strengthening the Essential Public Health Functions**
Type	Short course
Organisation	The World Bank
Overview	The course covers the 11 Essential Public Health Functions. The course develops leadership and competencies in the assessment and performance of the 'Essential Public Health Functions' (EPHF), and contribute to the strengthening of effective national public health systems. The overall objective of the course is to develop leadership and competencies in the assessment and performance of the 'Essential Public Health Functions' (EPHF), and contribute to the strengthening of effective national public health systems.
Fee	$750

Audience	Ministries of Health, mid- level policy makers, World Bank staff, development agency and donor agency staff and other agents of change
Country / Region	US
Language/s	English (Spanish, Portuguese and Chinese in the near future)
Mode of Study	Distance learning (160 hrs)
Link	http://info.worldbank.org/etools/wbi_learning/activity.cfm?sch_id=HNP10-01-285
Contact	Ms Jo Hindriks email: jhindriks@worldbank.org Tel.: 1-202-4736425 Fax: 1-202-6760961
Region	**AFRICA**
Name	**Community Development Resource Association, South Africa (CDRA**
Type	Organisation (NGO)
Overview	Offers learning programmes (courses) aimed at supporting effective and developmental practices and ongoing learning in the individual practitioners, organisations and networks.
Funding	Various sources
Country / Region	South Africa
Language/s	English
Link	http://www.cdra.org.za/WorkandServices/Courses%20at%20CDRA.htm
Contact	Address: 52/54 Francis Street, Woodstock, Cape Town, South Africa Tel: -27 -21 462 3902 Fax: -27 -21 462 3918 Postal address: P.O. Box 221, Woodstock, South Africa, 7915 email: info@cdra.org.za
Name	**Accelerated Health Officer Training Program**
Type	Training course
Organisation	Ethiopia Public Health Training Initiative (EPHTI)
Overview	A pre-service health staff training to become a health officer and the leader of the community-based health Center professional staff. The program's objective is to train 5,000 new health officers by 2010.
Partners	Carter Center (US) & Ministry of Health Ethiopia
Country	Ethiopia
Language/s	English
Link	http://www.cartercenter.org/health/ephti/index.html
Contact	The Carter Center One Copenhill 453 Freedom Parkway Atlanta, GA 30307 Phone: (404) 420-5100 or (800) 550-3560 email: carterweb@emory.edu

Name	**AMREF Courses & Training Programmes**
Type	Short Courses
Overview	Offer a variety of short training courses for health workers at different levels with focus on capacity building
Organisation	African Medical and Research Foundation (country programmes in Kenya, Ethiopia, Uganda, Tanzania, Southern Sudan and South Africa, training and consulting support provided to an additional 30 African countries)
Funding	Swedish International Development Cooperation Agency (Sida), and the Canadian International Development Agency (CIDA)
Country	Kenya
Language/s	English
Duration	Range: 1-4 weeks
Mode of Study	Various (including online courses)
Accreditation	AMREF certificate
Link	http://www.amref.org/info-centre/amref-courses--training-programmes/short-courses-for-2009/
Contact	AMREF Headquarters PO Box 27691-00506 Nairobi, Kenya Fax: +254 20 609 518 Tel: +254 20 699 3000
Region	**EASTERN MEDITERRANEAN**
Name	**Systems-Oriented Health Investment Program (SOHIP), Pakistan**
Type	Organisation
Overview	Capacity building focused on system strengthening within a health promotion framework in two districts
Funding	Canadian International Development Agency (CIDA)
Partners	Department of Health, provincial Government of Punjab, and the Departments of Health in the District Governments of Pakpattan Mianwali
Country	Pakistan
Language/s	English
Link	http://www.agriteam.ca/projects/profile/systems-oriented-health-investment-program-sohip/
Contact	Project Manager: Morag Humble email: mhumble@agriteam.ca Address: Suite 200 14707 Bannister Road S.E. Calgary, Alberta T2X 1Z2 telephone: 403-253-5298 fax: 403-253-5140 email: info@agriteam.ca

Name	**Healthy Cities Programme Training Course: Local Action Manual**
Type	4 Module Guide for Master Trainers
Overview	The aim of this manual is to orientate and guide master trainers in each country, and to train national and local healthy city coordinators, committee members, local partners, nongovernmental organizations, stakeholders and key personnel involved in healthy settings on practical ways and procedures for the effective implementation of the programme. The modules contain strong health promotion capacity building components.
Organisation	WHO
Country / Region	Eastern Mediterranean Region
Language/s	English
Duration	5 days
Mode of Study	Interactive presentations, group work, practical exercises, field visit to a programme area and other assignments
Accreditation	
Link	http://www.emro.who.int/cbi/pdf/healthcities_manual.pdf
Contact	Community Based Initiatives World Health Organization Regional Office for the Eastern Mediterranean P.O. Box 7608 Nasr City Cairo 11371 Egypt Tel: +2(02)26702535/276 5307 Fax: +2(02)2670 2492/4 e-mail: CBI@emro.who.int
Region	**EUROPEAN**
Name	**Health Programme**
Type	Organisation
Organisation	Aga Khan Development Network's (AKDN)
Overview	Strengthening health of the country with health promotion capacity building as a component of policy/strategy
Country	Tajikistan
Link	http://www.akdn.org/tajikistan_health.asp
Contact	Aga Khan Development Network (AKDN) 1-3 Avenue de la Paix 1202 Geneva Switzerland Tel: +41 22 909 7200 Fax: +41 22 909 7291 email: info@akdn.org
Region	**PAN AMERICA**

Sub Region	**NORTH AMERICA**
Name	**MPH (Health Promotion Specialization)**
Type	Graduate program
Organisation	Dalla Lana School of Public Health
Region/Country	Canada
Duration	20-24 month
Language/s	English
Brief	Health Promotion specialization with a social science emphasis on health and health promotion issues and Skills in Implementing and Evaluating Health Promotion Programs
Mode of study	Self Directed Study/On-line
Accreditation status	North Central Association (NCA)
Link	http://www.phs.utoronto.ca/mhsc_health_promotion.asp
Address	Ted Myers Ph.D., M.Sc., M.S.W., B.A. Professor Social and Behavioural Health Sciences Dalla Lana School of Public Health Health Sciences Building 155 College Street Toronto, ON M5T 3M7 (416) 978-8979 email: ted.myers@utoronto.ca
Name	**HP-101 Course**
Type	Additional professional development
Organisation	Ontario Health Promotion Resource System (OHPRS)
Funding	Ontario Ministry of Health and Long Term Care, Ministry of Children and Youth Services
Partners	22 member organizations
Country	Canada
Duration	no specific time-frame, self-directed learning
Language/s	English & French
Overview	Introduction to Health Promotion (HP) concepts, theories and resources
Distance learning	Free self-study online course, no registration required Guided discussions (web conferences) require registration, if available
Accreditation status	not an accredited course
Link	http://www.ohprs.ca/hp101/main.htm
Address	Ontario Health Promotion Resource System Secretariat c/o Health Nexus 180 Dundas Street West, Suite 1900 Toronto, Ontario M5G 1Z8 Phone 416-408-2249

	Toll-free 1 800-397-9567 Fax 416-408-2122
Name	**The Presidential Management Fellows (PMF) Programme**
Type	Training fellowship (paid)
Overview	Training fellowship in public health leadership and management
Organisation	Centers for Disease Control and Prevention (CDC), Atlanta
Country	US
Language/s	English
Duration	2-year
Link	http://www.cdc.gov/PMF/
Contact	Presidential Management Fellows Program Centers for Disease Control and Prevention 1600 Clifton Rd, N.E., Mailstop E-92 Atlanta, GA 30333 Phone: 404-498-6587 email: pmf@cdc.gov
Name	**CARMEN Network**
Type	Selected schools of Public Health working in partnership with public health agencies, and health institutions/organizations in the development/updating of various **training activities**
Overview	Initiative aimed at giving technical cooperation to Member States for the implementation of effective integrated community–based NCD prevention programs focusing on development of necessary workforce competencies
Organisation	PAHO
Country / Region	USA
Link	http://ncd.bvsalud.org/carmen/en/
Contact	Pan American Organization Regional Office of the World Health Organization 525 23rd Street, N.W. Washington, D.C. 20037-2895 Phone: 1 (202) 974-3000 FAX: 1 (202) 974-3331 email: carmen@paho.org
Name	**Health Communication Partnership (HCP)**
Type	Programme
Overview	Capacity building in HCP is focused on local institutions in developing countries to develop health communication programs. One of the strategies to build capacity is "Collective Learning and Action" (CLA) approach involving targeted training for specialized expertise for result-oriented participatory learning.
Organisation	USAID & John Hopkins Bloomberg School of Public Health
Country / Region	USA based, Global

Language/s	English
Link	http://www.jhuccp.org/legacy/topics/capacity.html
Contact	Jose G. Rimon II HCP Project Director The Johns Hopkins University 111 Market Place, Suite 310, Baltimore, MD 21202 Fax: 410-659-6266 Phone: 410-659-6300 email: info@hcpartnership.org
Name	**ETR (Education, Training, Research) Associates**
Type	Organisation
Overview	Offers educators and healthcare professionals different mechanisms to earn continuing education credits and fulfil professional development requirements and trainings and other educational activities in association with the following credentialing programs: CHES - Certified Health Education Specialists CFLE - Certified Family Life Educators
Funding	CDC
Country / Region	Canada (Scotts Valley)
Language/s	English
Link	http://programservices.etr.org/index.cfm?fuseaction=services.detail&capID=2#39
Contact	Francisco Buchting, Ph.D. - Vice President, Program Services Division email: franciscob@etr.org Corporate Office 4 Carbonero Way Scotts Valley, CA 95066 Tel: (831) 438-4060 Fax: (831) 438-4284
Name	**The Managers Electronic Resource Center**
Type	Organisation
Overview	Electronic compendium of tools to assist health professionals to provide accessible, high quality trainings and sustainable health services including leadership and human resource management
Partners	Management Sciences for Health (MSH), USAID, UNICEF
Country / Region	US based
Language/s	English
Link	http://erc.msh.org/
Contact	**MSH Headquarters** Management Sciences for Health 784 Memorial Drive

	Cambridge, Massachusetts 02139 United States Telephone: 617.250.9500 Fax: 617.250.9090 e-mail: communications@msh.org
Name	**Health Education Courses**
Overview	Various courses offered with focus on professional development of Health Promotion competencies as a requirement for becoming a Health Educator
Organisation	University of Mexico
Country	United States
Language/s	English
Duration	various
Mode of Study	Online and on campus
Accreditation	
Link	University Health Education Dept.: http://coe.unm.edu/healthed/HealthEducationHome/tabid/516/Default.aspx Courses list and description: http://coe.unm.edu/Portals/0/Files/Academic_Programs/Catalog_Sections/HealthEduc.pdf
Contact	Health Education Program MSC04-2610 1 University of New Mexico Albuquerque, NM 87131-0001 Tel: 505-277-5151 Fax: 505-277-6227 email: Dr. Elias Duryea (Program Coordinator) duryea@unm.edu
Sub Region	**LATIN AMERICA**
Name	**Putting It All Together**
Type	Competency-Based Training For Adolescent Reproductive Health Care Providers
Overview	course to train providers in key adolescent reproductive health competencies which include adolescent-specific counselling and health promotion skills, an increased understanding of adolescent development and human sexuality, prevention of STIs, contraceptive technology, and design of adolescent-friendly services
Organisation	Pan American Health Organization (PAHO), the Johns Hopkins University/School of Public Health (JHU/SPH) and Center for Communication Programs (JHU/CCP)
Country	Latin America
Language/s	English
Duration	
Mode of Study	via Multimedia CD-ROM
Accreditation	
Link	http://www.jhuccp.org/la/regional/paho.shtml#2
Contact	The Johns Hopkins University 111 Market Place, Suite 310, Baltimore, MD 21202

Name	**Universidad Nur (Nur University)**
Type	University
Overview	Private, not-for-profit development-oriented university. Offers distance education and extension programmes in various disciplines with focus on developing skills and human capabilities.
Country	Bolivia (locations: Santa Cruz, Cochabamba, and La Paz)
Language	Spanish
Mode of Study	On campus, distance learning and extension programmes
Accreditation	
Link	http://bit.ly/83WcEf
Contact	Universidad Nur Av. Cristo Redentor Nro. 100 P.O. Box 3273 Santa Cruz Bolivia Tel: 591 3 336 3939 email: info@nur.edu
Name	**Especialidad en Promoción de la Salud**
Organisation	El Instituto Nacional de Salud Publica (INSP)
Overview	Health Promotion specialisation based on competencies
Country / Region	México
Language/s	Spanish
Link	http://www.insp.mx/Portal/prog-academ/OfertaAcademica/especialidad/promocion/fundamentacion.php
Contact	Universidad No. 655 Colonia Santa María Ahuacatitlan, Cerrada Los Pinos y Caminera C. P. 62100, Cuernavaca, Mor. México Tel: (777)329 3000
Region	**SOUTH EAST ASIA**
Name	**Siam Health Foundation (SHF)**
Type	Organisation
Overview	Provides training programs and skills management as a human resource management training institute working in Asia, in collaboration with different universities, faculties, institutions and government and non government organizations around the world
Country	Thailand
Language/s	English
Link	http://www.siamhf.org/hrmtraining.html
Contact	SIAM Health Foundation, 98/68 Perfect Place: Sukumvit 77- Subarnabhumi Sukumvit 77 Road, Rajarteva subdistrict, Bangphi, Samutprakhan 10540 Bangkok Thailand. Phone: 66 (0)-863396025 (M) e-mail: siamhf@gmail.com