

THE ROLE OF PROFESSIONAL EDUCATION IN BUILDING CAPACITY FOR HEALTH PROMOTION IN THE GLOBAL SOUTH: A CASE STUDY FROM NORWAY

The capacity to train public health professionals is far from sufficient to meet urgent global needs. Foreign aid programs hold much promise to deal with this challenge. A case study from Norway illustrates the possibilities. Since the early 1960s, Norwegian universities have offered English-taught masters and doctoral degree programs, with sufficient financial support that all Third World students have the resources to complete training, regardless of their personal financial circumstances. This facet of the program is its main distinguishing factor, compared to many educational opportunities that are available in other countries. Since the first visiting students were awarded degrees in 1968, almost 10,000 students have participated at more than 25 Norwegian institutions, including many offering public health training. Many eligible applicants have been turned away due to lack of resources, indicating a level of interest that cannot be met with existing resources. Similar programs in more countries could help alleviate the need. (*Ethn Dis.* 2003; 13[suppl2]:S2-35–S2-39)

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From the Research Centre for Health Promotion, University of Bergen, Bergen, Norway.

Address reprint requests and correspondence to Professor Maurice B. Mittelmark, BS, MA, PhD, FACE; Research Centre for Health Promotion; University of Bergen; Christiesgt. 13, 5015 Bergen, Norway.

¹The academic term Global South, or 'South,' refers to populations of the world characterized by a lack of many supports and systems that are prerequisites for thriving societal life, however that might be defined. These prerequisites include peace and security, freedom of belief, thought and expression, adequate participatory economic and governance mechanisms, and equitable access to living essentials, as well as life-enhancing technologies, among other foundations for worthy living. The term 'worthy living' is meant to express the idea that no certain international material standard exists, and that the conditions essential to worthy living vary by place, culture and time. However, modern means of social exchange are quickly leading to consensus about the minimum conditions for worthy living.

INTRODUCTION: CHALLENGES

In many countries of Africa, Asia, Eastern Europe, the Middle East, and Central and South America, also known as the global South,¹ the capacity to train public health and health promotion professionals is far from sufficient to meet the urgent needs. The lack of trained public health professionals is a gadfly in the global response to growing threats from communicable and non-communicable diseases.

For many diseases and health-threatening conditions, proven public health and health promotion technologies are readily available, but cannot be implemented to their full potential due to a lack of adequately trained and equipped local health professionals. There is need for qualified practitioners anchored in third world localities, but also for public health administrators, researchers and educators. This emphasis on indigenous

The population of the South is by far the dominant proportion in the world. Recent socio-political changes have blurred the North-South distinction. Just as the terms First, Second and Third World have faded in meaning since they were first used to group Western market economies, the Soviet Bloc, and non-aligned countries, the South no longer encompasses Southern Hemisphere populations almost exclusively. Today, it includes parts of Eastern Europe, and arguably, population segments in places such as North America, Western Europe, and many indigenous peoples worldwide. The term Third World remains a popular, but inadequate descriptor, for reasons that are obvious from this note.

The specific countries, regions and territories to which this paper refers are listed in the appendix, identified by the Norwegian Government as eligible during 2003 for participation in the education program that is the subject of this paper.

Maurice B. Mittelmark, MA, PhD

expertise acknowledges the critical cultural dimension of effective public health practice. Among the most cost-effective approaches to disease prevention and health promotion, for example, are community-based approaches to health program planning, implementation, and evaluation. Public health workers who 'belong' to the communities in which they work enjoy advantages that are simply unrealistic for even the best trained and motivated visiting professionals.

Public health work should be based on best practices as demonstrated through health promotion research, with rational adjustments to suit local conditions. This is so not only for community-based intervention, but also in the stimulation of healthy policy, needed to establish the social and physical environmental conditions that support improved public health. All public health workers need the skills to evaluate critically the published evidence on health promotion's effectiveness. They need the skills, too, to evaluate their own initiatives and disseminate results to others.

The needs described above call for an approach to capacity building that emphasizes deep and long-term commitment to creating a public health work force that is professional, local, and connected to the international public health network. However, virtually all the countries in the regions under discussion lack the basic training resources and support facilities to provide the needed training. There is no lack of well-qualified candidates for public health training; all countries in these regions have higher education systems through which at least some citizens attain the basic qualifications required for advanced training in the health professions.

The international response has been to open training programs in developed countries to third world students. Indeed, such students are viewed as an important market segment in the increasingly competitive and market-driven higher education arena. This has been a boon to a tiny minority from developing countries who have the wherewithal to pay the tuition and living costs associated with study at universities, which offer advanced public health education. However, many such institutions depend on substantial student fees to finance the education they offer. As result, there is inequity of opportunity for advanced study, too few training opportunities to meet the need in general, and too few trained professionals with ties to the communities where the need is greatest.

The thesis of this paper is that well-designed foreign aid programs hold much promise to deal with the challenges outlined above. The following case study from Norway illustrates the possibilities. The Norwegian case is not a rarity, rather it is offered as illustrative of possibilities that have, until now, not been as well developed as could be hoped.

THE NORWEGIAN FOREIGN AID HIGHER EDUCATION PROGRAM

Foreign aid in its post-World War II form has had twin objectives, as described recently by the World Bank.¹ The first objective is to promote long-term growth and poverty reduction, motivated by a mix of altruism and self-interested concern with the economic and security benefits that poverty reduction could stimulate. The second objective is to promote the short-term political and strategic interests of the donors.

An emphasis on poverty reduction through education is an overriding strategy of NORAD, the Norwegian Agency for Development Cooperation.² Nor-

wegian society views education as a fundamental human right, translated at home into universal coverage of educational costs by the State, at all levels of training, including post-graduate specialization. This perspective carries over into the Norwegian aid program, wherein education is viewed as a central strategy for the development of knowledge, competence, and sustainable development in the South's social, technological, and business sectors.

Since the early 1960's, NORAD has collaborated with Norwegian universities and colleges to deliver education aid programs that offer specially designed English-taught masters and doctoral degree programs. These programs fund full periods of study taken in Norway or the home country.

Most foreign students accepted for study in Norway under these programs receive a tuition-free education, and are eligible for State loans sufficient to cover most or all living expenses. The loans normally convert to gifts when the students complete training and leave Norway. This helps to avoid 'brain drain' problems that can happen when financial arrangements are not linked clearly and decisively to the conditions for loan/gift conversion. Students may also receive funding for fieldwork and annual travel from and to home. The State Loan Fund cooperates with NORAD and higher education institutions to arrange tailored funding solutions that meet the requirements of even the neediest visiting students.

The main point of the Norwegian approach is this: all visiting students from eligible countries should have the resources to complete training, regardless of their financial circumstances. This facet of the program is its main distinguishing factor, compared to many educational opportunities that are available in other countries. It is also important that training for visitors is integrated with training for Norwegian students, with all instruction in English. This facilitates a learning experience for

both groups that adds special value to the program, beyond the immediate educational considerations.

NORAD's education programs were launched in 1962, and since the first visiting students were awarded degrees in 1968, almost 10,000 students have participated at more than 25 Norwegian institutions. In recent years, about 1,200 new students have been admitted each year. Many, if not most, of the applicants not selected are eligible, indicating a level of interest in the program that cannot be met with existing resources. Almost all the degree-granting programs at the Norwegian universities and colleges wish to admit greater numbers of visiting graduate students from eligible lands, and only financial constraints stand in the way. Nevertheless, NORAD's financial commitment to higher education programs is not trivial, amounting to about 26.6 million annually in recent years.³

Several of NORAD's programs are health-related, including the University of Oslo's M.Phil. in International Community Health and the University of Bergen's M.Phil. in Health Sciences and M.Phil. in Health Promotion. To illustrate the reach of these programs, Table 1 offers information on the Bergen health promotion program and its 92 students selected from 24 countries between 1992 and 2000 and 17 more students selected in 2002. Greater than 90 percent of these students have completed studies and received the masters degree. Approximately 27 percent of these students go on to doctoral training in public health or health promotion, either at the University of Bergen or elsewhere. Complete descriptions of the program are available elsewhere⁴⁻⁵ and learning objectives for the health promotion policies and programs can be found in Appendix 2.

SUMMARY

This brief paper has described an approach to capacity building for public

Table 1. Enrollment in the MSc/MPhil degree program in health promotion

Country	1992	1994	1996	1998	2000	Total
Belgium		1				1
Denmark	1			1		2
Ghana						2
England	1				2	1
Estonia		2	1	1		5
Ethiopia	2				1	2
Finland						1
Hungary			1	1	1	2
Iceland			1			1
Kazakhstan						1
Kenya				1	1	1
Latvia		2	1			3
Nepal				1		1
Nigeria				1		1
Norway	12	8	5	8	5	38
Palestine		2	1			3
Romania		1			1	2
Rwanda					1	1
Slovenia			1	1		2
Sweden					1	1
Tanzania	2	3	2	4	2	13
Uganda			1	1	1	3
USA					2	2
Zimbabwe		1	2			3
Total	18	20	16	20	18	92

health and health promotion that emphasizes the role of higher education, the development of indigenous health professionals, and the importance of links between well-resourced countries and partner countries that have sound human resources, but lack sufficient training capacity. This is not a report of an experiment, but rather, it is a summary of a proven approach that has been in operation for more than 40 years. The hallmark of the approach is the equity framework within which it is constructed, with the central idea that qualified students from under-resourced countries should have access to graduate training in public health, regardless of ability to pay. Modest programs such as those available in Norway, a country of just 4.5 million inhabitants, cannot begin to meet the demand, and new partners are needed. The Norwegian experience shows that the rewards of a serious and sustained commitment can be substantial.

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Appendix 1. Countries identified by the Norwegian Government in 2003 as eligible for participation in its education program.

Afghanistan	Azerbaijan	Micronesia
Algeria	Belorussia	Morocco
Angola	Bosnia-Herzegovina	Mongolia
Bangladesh	Bulgaria	Mozambique
Belize	Croatia	Myanmar
Benin	Czech Republic	Namibia
Bhutan	Estonia	Nepal
Bolivia	Yugoslavia	Nicaragua
Botswana	Georgia	Niger
Burkina Faso	Hungary	Nigeria
Burundi	Kazakhstan	Niue
Cambodia	Kyrgystan	North Korea
Cameroon	Latvia	Pakistan
Cape Verde	Lithuania	Philippines
China	Macedonia	Panama
Central African Republic	Moldavia	Papua New Guinea
Colombia	Poland	Paraguay
Comoros	Romania	Peru
Congo	Russian Federation	Rwanda
Costa Rica	Slovakia	São Tomé and Príncipe
Cuba	Slovenia	Senegal
Democratic Republic of Congo	Tajikistan	Sierra Leone
Djibouti	Turkmenistan	St. Vincent and the Grenadines
Dominica	Ukraine	Solomon Island
Dominican Republic	Uzbekistan	Somalia
East Timor	India	Sri Lanka
Ecuador	Indonesia	Sudan
Egypt	Iraq	Swaziland
Equatorial Guinea	Iran	Syria
El Salvador	Ivory Coast	South Africa
Eritrea	Jamaica	Tanzania
Ethiopia	Jordan	Tchad
Fiji	Kenya	Thailand
Gambia	Kiribati	Togo
Ghana	Laos	Tonga
Grenada	Lebanon	Tunisia
Guatemala	Lesotho	Tuvalu
Guinea	Liberia	Uganda
Guinea-Bissau	Madagascar	Vanuatu
Guyana	Malawi	Vietnam
Haiti	Maldives	West-Samoa
Honduras	Mali	Yemen
Albania	Mauritania	Zambia
Armenia	Marshall Islands	Zimbabwe

Palestinian students registered at one of the universities listed below are also eligible to apply for admission to the Quota-Program:

An-Najha, Nablus	Al-Azhar, Gaza	Gaza Islamic, Gaza
Al-Quds, Jerusalem	Bethlehem	Hebron
Al-Quds open, Jerusalem	Birzeit	

Appendix 2. Learning objectives

Certain areas of competence are viewed to be the very core of health promotion practice and the evaluation of health promotion policies and programs. Every student must develop and demonstrate mastery in these areas. The program uses these learning objectives to set priorities for module content and to guide appraisal of student progress and performance:

1. Central concepts, theories and models in health promotion
 - a. To have a basic understanding of the concepts of health, quality of life, illness and disease, and to be able to distinguish between the concepts of disease prevention and health promotion.
 - b. To be able to identify and compare the merits and limitations of theories pertinent to health promotion research.
 - c. To be able to critically discuss health promotion from a public health perspective.
 - d. To be able to critically discuss health promotion from a public policy perspective.
 2. Public health
 - a. To be able to identify the most important national, regional and international public health problems.
 - b. To be able to define the most important determinants of health in populations and their relative contribution to mortality, morbidity and functional limitation.
 - c. To have a basic understanding of risk assessment and of impact assessment in individuals, groups and populations.
 - d. To have a basic understanding of the ecological relationships between health, environments, and resources in a local and global context.
 3. Research and evaluation
 - a. To understand the processes of applied research and evaluation.
 - b. To have basic skills in quantitative and qualitative research methodologies applicable for health promotion research and evaluation, including the proper use of statistical procedures.
 - c. To have the ability to critically read research literature in the field of health promotion.
 - d. To be able to plan, conduct, analyse, and report on a health promotion investigation.
 4. Health promotion practice
 - a. To have a critical understanding of a range of societal, social, group-oriented and individual strategies and actions for health promotion.
 - b. To have the ability to assess health needs and opportunities for health promotion action in groups, communities and populations.
 - c. To have the ability to develop plans for health promotion action and strategies in groups, communities and populations.
 - d. To have basic skills in project management and collaborative work as applied to health promotion.
 - e. To have basic skills in evaluation methods applicable for health promotion programs.
 5. Professional behavior and ethics
 - a. To be capable of reflecting on and assessing one's own value system and how it has an impact on professional behavior.
 - b. To be able to critically assess ethical aspects of health promotion initiatives and actions.
 - c. To be able to apply appropriate ethical guidelines in the design and conduct of research.
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