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Emily Darlington, Julien Masson

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Challenges and perspectives on how to articulate social inequalities, equity, citizenship and solidarity in health promotion

**Emily Darlington, Julien Masson**

**Université de Lyon, Université Claude Bernard Lyon1, Laboratoire P2S EA 4129**

This issue of the journal *Education, Santé, Sociétés* aims to propose a critical reflection on the articulation between health education and prevention based on equity, citizenship and solidarity, from the perspective of health promotion. Through a collection of field experiences, ethical reflections and critical analysis, this issue aims to question the theoretical and conceptual foundations of health education and prevention strategies, from their design to their articulation through the implementation of field actions and programmes. Our perspective is in line with multi-referential and plural analysis approaches (Ardoino, 1990) which respond to the complexity of the phenomena considered in health promotion research. Such complexity requires the intersecting perspectives of different disciplines and the articulation of different types of knowledge, in hope to acquire a detailed and coherent understanding of the holistic nature of such complex phenomena (Koelen, Vaandrager, & Colomé, 2001). This issue, which is in step with the widely debated reflexions at the 7th edition of the international conference of the Unirés network in Paris (in October 2018), is open to the scientific community as a whole: it thus assumes the diversity of viewpoints, the complementarity of disciplines and the singularity of the contexts presented in the articles chosen.

### **Thinking in line with the current context**

The relevance of health promotion actions/interventions is well established as they are at the core of international and national political strategies. In 2011, Sir Marmot recalled the importance of action on the social determinants of health (Marmot, 2011) in the 6 areas presented in the "Marmot Review": 1- to give every child the best start in life; 2- to improve lifelong education; 3- to create fair jobs and employment; 4- to ensure a minimum level of financial resources to guarantee a healthy standard of living; 5- to create healthy and sustainable communities; 6- to use prevention approaches focused on health determinants (Marmot & Bell, 2012). The various forms of empowerment, at the material, psychosocial and political levels, make it possible to create the conditions for social justice with a view to countering the effect of social gradient (Marmot, 2010).

The Shanghai Declaration of 2016 (World Health Organization, 2016) reaffirmed the importance of linking the agendas of social development, social justice, equity and health with the environmental and sustainable development issues at the heart of our current societies in ALL public policies, a point which had already been highlighted by the Commission on Social Determinants of Health.

In France, the “Stratégie Nationale de Santé” (National Health Strategy) places health as the focal point of all public policies and questions the current stakes in terms of prevention in the light of the health determinants. In this perspective, health policies must aim to reduce health inequities based on democratic processes founded on equity and solidarity, while integrating current environmental and societal challenges, working towards social transformation (French Ministry of Solidarity and Health, 2017). Conflicting views were being voiced within WHO itself on the relevance of strategies which target health determinants, as Sir Marmot points out. However, how can we ignore "the causes of the causes"? (Marmot, 2011) when addressing health inequalities? The existence of a "health gradient", which refers to the link between a person's position<sup>1</sup> in the social structure and their health status, was already highlighted in the 1980 Black Report (United Kingdom). This was confirmed by Potvin, Moquet, & Jones in 2010 when they pointed out that "socially stratified differences in health status... reproduce, in the field of health, the inequalities which exist between social groups" (Potvin, Moquet, & Jones, 2010, p. 30). As the Commission on Social Determinants of Health points out, the reduction of health inequalities does not solely target the effectiveness of strategies, but is also an ethical imperative as "social injustice kills on a large scale" (WHO Commission on Social Determinants of Health, 2008, p. 40). Thierry Lang's<sup>2</sup> 2010 and 2012 reports, and the subsequent work carried out by the Haut Conseil de Santé Publique (High Council of Public Health) in 2016, reported on the limited effectiveness of the policies implemented to reduce health inequalities in France so far. Potvin et al. point this out: when undertaking to reduce health inequalities, "good will is not enough" (Potvin & al., 2010, p. 26), while this pressing issue is indeed a priority, and even a global emergency.

The field of health promotion research has taken on to reduce health inequalities, in compliance with the terms of the Ottawa Charter, by focusing on “ the process of enabling people to increase control over, and to improve, their health”. (WHO, 1986). Health promotion actions, interventions and programmes thus target the determinants of health, not just individual behaviours.

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<sup>1</sup> Guichard and Potvin provide the following definition of social position « By social position, we mean the situation of a given individual on the social scale often considered in terms of age, education, employment and level of income. » p39

<sup>2</sup> In 2016, Thierry LANG, University of Toulouse III presided the working group on health inequalities at the Haut Conseil de Santé Publique (High Council of Public Health).

Moreover, Ridde argues the distinction between health promotion - which aims to reduce health inequalities - and public health, which aims to improve the health status of a population (Ridde, 2007) lies precisely therein. While the reduction of health inequalities can contribute to improving the health of populations, the methods to be used to achieve these objectives are not quite the same. The knowledge mobilized, the place of the individual and their potential power to act, the values and postures of the professionals and the policy decision-makers involved in these approaches based on equity are not exposed to the same ethical reflections, nor are such reflections resolved in the same way. In this issue, we propose to put into perspective the stakes raised by such a multiplicity of models, knowledge and points of view, both in terms of the articulation of these models and theories, which are situated at the crossroads of educational and health research, and in terms of their analysis, in the light of the theories relating to democracy in health and social justice, which are key concepts when referring to the principles of equity, solidarity and citizenship. Finally, this issue focuses on the professionals who enable the materialization of such theories into practice (and vice versa), the stakes of inter-sectorality, professional postures and conceptions also deserving our attention.

### **Epistemological implications for Health Promotion**

While key concepts and definitions can be found, theoretical models underlying the design of health education and prevention research, of health education and prevention programmes, projects and tools, and more broadly health promotion, are numerous. The evolution of the concept of health since the 1946 WHO definition illustrates such differences, both from an epistemological point of view, and in the focus and frameworks of analysis chosen in research projects, programmes and tools. By introducing the psychological and social dimensions of health, the 1946 WHO definition proposes a "positive" definition of health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The previous definition of health described as "negative", as the opposite of disease or pathology, required detailed knowledge of the physiological functioning of a body considered as being "normal". Much emphasis was placed on medical and biological knowledge, with little consideration for individuality, emotional existence, or the experience of physiological manifestations, let alone the context of living and the conditions in which such physiological manifestations are expressed.

But are the objectives set in the 1946 definition not somewhat utopian? Huber offers an enlightening analysis of this definition, which hypothesizes a state of "complete" well-being is difficult to achieve (Huber & al., 2011). Recalling the works of Larson (Larson, 1996), Huber considers that if this state of complete well-being is a sine qua none condition for an individual's health, would (almost)

all of us not be considered in poor health? Would health be attainable in all parts of the world, regardless of political regime and under any circumstances? The terms of such a definition are not merely a semantic debate; such terms have a major impact on the strategies, means, approaches but also the policies developed to achieve and maintain health; the impact of such terms is also major on the key professionals mobilized to achieve the objectives which are implicitly formulated by this definition. If health is the absence of disease, strategies based on the linear causal relationships which target the risk factors for disease seem entirely relevant, thus calling for the professionals specifically trained on these issues to be mobilised on the front line; if health is this state of complete three-dimensional well-being, a single approach seems difficult, if not impossible.

The Ottawa Charter of 1986 points to another approach towards health (WHO, 1986), demonstrating a major paradigm shift in the integration of the socio-environmental dimensions in individuals' health. This highlights the fundamental role of the multiple factors at play in the health of individuals but also of populations. In the Ottawa Charter, "Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources as well as physical capacities" (WHO, 1986, p1). Health would thus no longer be a state, but a balance in physiological functions (maintained or restored), a capacity to adapt to stress, to self-regulate, an ability to lead an independent life, and express one's social potential in ways which one defines for oneself (Huber & al., 2011).

Promoting health, promoting "health-promoting behaviour", prevention and health promotion, education, risk prevention, prevention of non-communicable diseases all relate to the objectives formulated by such health promotion strategies. It is essential to recognise these terms are by no means interchangeable, as sometimes seen in programmes and projects and even research. However, these terms are not mutually exclusive, nor do they oppose each other. They refer to solid theoretical foundations which have been firmly anchored in the international scientific community working on health promotion for many years. It is indeed the building of scientific knowledge that has motivated the multiplication of the models, the theories and the approaches, which underpin health promotion strategies in all settings and from a perspective of equity and solidarity.

### **What data, what research are needed to develop health promotion strategies based on equity and aiming to reduce health inequalities?**

To approach health education and health promotion through the lens of citizenship also requires the objectives, strategies and methods to be rooted in the reduction of health inequalities based on equity and solidarity principles, while integrating individual as well as population health

issues. By "citizenship", we mean a social form of solidarity and not the exercise of a right or equality before the law (Castel, 2008). With respect to equity in health, Braveman and Gottlieb define it "(...) both as the absence of systematic disparities in health and the determinants of health **and** the principle underlying a commitment to reduce - and, ultimately eliminate - disparities in health and in its determinants, including social determinants" (Braveman & Gottlieb, 2014, p6). Griffith et al. point to the fundamental importance of qualitative research in identifying and understanding health inequalities. This endeavour must take into account and report on the experiences of individuals, professionals, and decision-makers, thus restoring to the notion of health but also of illness their full social dimension (Griffith, Shelton, & Kegler, 2017). Along the same line, Braveman and Gottlieb emphasize that undertaking a detailed and systemic analysis of such complex phenomena does not easily lend itself to randomized trials (Braveman & Gottlieb, 2014).

However, the growing interest in health inequalities and the social determinants of health has come up against the complexity of the mechanisms at work between social factors and health (Braveman & Gottlieb, 2014). The authors even indicate some of the scientific data highlighting the influence of specific health determinants is controversial. Also, Griffith et al. raise the difficulty to measure progress when tackling health inequalities, inasmuch as the description of modifiable disparities is difficult. This difficulty is all the greater when knowledge is accumulated to contribute to reducing health inequalities with a view to achieving health equity (Griffith & al., 2017). The evaluation criteria used to ensure the validity of the knowledge collected on health determinants are indeed the subject of (another) epistemological debate (Braveman & Gottlieb, 2014). Similarly, the complex interventions which address complex health issues, such as the reduction of health inequalities, must also be subject to epistemological questioning regarding the data collected to evaluate their effectiveness (Hawe, Shiell, & Riley, 2004).

Now another question seems key: how can citizens be involved in the design of research from a contextualized, participatory and translational perspective? Translational research, whether it consists of "bedside" research by clinicians, of the use of data produced by research from public health practices, particularly those related to health systems (Woolf, 2008) or of prevention initiatives directed towards communities (Fagan, Hanson, Hawkins, & Arthur, 2009), seems to be highly relevant in the field of the reduction of health inequalities (Dankwa-Mullan & al., 2010). Dankwa et al. specify this type of research is particularly important for populations in a less favourable situation with regard to inequalities. Pawson et al. add research data syntheses must incorporate the complexity of the interventions they are intended to report on, particularly in the design of public policy (Pawson, Greenhalgh, Harvey, & Walshe, 2005).

To open this issue, Wamba's article proposes an analysis of the foundations of a scheme which is supposed to reduce the health inequalities in Cameroon: the "banque malheur" (misfortune bank). Wamba questions the knowledge which makes it possible to objectivise inequalities - in this case inequalities in the access to healthcare - recalling "the reality faced by health care users" is not always (well) represented in research data. Wamba hypothesizes an analysis of the mechanisms of this scheme, which aims for equity, would make it possible to identify certain processes that create inequities in access to healthcare in Cameroon.

### **Articulating educational and health approaches to reduce health inequalities: what are the stakes?**

Health education and prevention: articulating the two strategies is obvious from the point of view of health promotion (Jakarta Declaration, 1997; WHO, 1986); the evolution of concepts in the field of health promotion, as mentioned above, having contributed to the complexity of the strategies which should be implemented (Nutbeam, 1998). Consideration of the determinants of health (Dahlgren & Whitehead, 1991) and their influence on the health of individuals has largely steered the design of health promotion interventions and programmes towards supersettings approaches (Bloch et al, 2014), community-based approaches (Fincham, 1992; Labonte, Woodard, Chad, & Laverack, 2002), and multi-level approaches, aligning formulated objectives as well as considering interactions between the factors involved in the implementation process (Darlington, Violon, & Jourdan, 2018). Social determinants have an impact on health through direct or indirect interactions which show in varying timescales (Braveman & Gottlieb, 2014), which may be described as a "domino effect". Braveman and Gottlieb also point out human behaviours can be key mediators or moderators of such interaction processes, but this is not always the case (Braveman & Gottlieb, 2014). Eymard had also raised the strategic operational stakes of the importance given to individual behaviour which in fact anticipates the responsibility (or even the guilt) of an individual in the promotion of their own health (Eymard, 2004). In 2009, McQueen underlined few intervention models are based on knowledge of the determinants of health (McQueen, 2009). Much research has since been conducted in that direction, and it would be risky to conclude this type of model does not exist. However, we can assume a great deal of knowledge has yet to be gained in this area, which has not been sufficiently explored so far in health promotion (Darlington, Mannix Mc Namara, & Jourdan, 2020; McIsaac, Storey, Veugelers, & Kirk, 2014).

Solar and Irwin postulate the determinants of health can be sorted into different categories (Solar & Irwin, 2010): the structural determinants which include the health system, governance, economic, social and public health policies, culture and social values, and which influence the

distribution of individuals in different strata of socio-economic position on the basis of their education, employment, income, gender and ethnicity. According to the authors, less favourable material conditions will increase individual risk behaviours in more disadvantaged socio-economic groups: health inequalities stem from the differences in exposure to intermediate determinants (material living conditions, psychological and behavioural conditions, and biological determinants) and vulnerability to health determinants. The combination of different approaches, as presented in of Downie, Fyfe, & Tannahill's well-known model (Downie, Fyfe, & Tannahill, 1990) then becomes key in the design of complex multi-strategy, multi-level programmes (Trickett & Beehler, 2013), in different types of settings (Whitelaw & al., 2001). However, one might deplore funding mechanisms remain largely focused on targeting specific problems or specific populations (Hawe, King, Noort, Jordens, & Lloyd, 2000), essentially on the basis of quantitative indicators, with a rather positivist anchoring. Let us refer to our preceding arguments. Our intention is not to make any claims, but to let the reader free to reflect critically. Nevertheless, we feel it is essential to emphasise the role of plural, pluri- and even transdisciplinary approaches in the genesis and the evaluation of health promotion projects. Bloch et al. even go so far as to state that without a global vision, without coordination, without an integrated approach, certain actions and interventions may be counterproductive in relation to each other (Bloch & al., 2014). For example, Bloch et al. present the case of smoking prevention among adolescents, which, according to the authors, requires joint action on the attitudes and habits of their parents, without which the benefits could be minimized or even cancelled out. As another example, education is identified both as an essential determinant of health (Dahlgren & Whitehead, 1991), but also as a preferred strategy for promoting health. Several hypotheses justify the relevance of educational strategies (Braveman & Gottlieb, 2014) depending on the difference in terms of objectives: education enables individuals to develop knowledge and skills which promote behaviours that are favourable to their health; a second hypothesis would be to consider that education enables access to better paid jobs and better working conditions, which will enable the individual to be less exposed to stress, live in a better neighbourhood and be less exposed to occupational risks, which will consequently have a preventive effect on a certain number of risk factors; finally, education may influence beliefs, subjective social status, and social relationships (Egerter, Braveman, Sadegh-Nobari, Grossman-Kahn, & Dekker, 2011). Education can therefore contribute to a preventive purpose: as stated before, health education and prevention are not mutually exclusive. Let us discuss here the importance of differentiating between the intended objective (or purpose), the strategy(ies) adopted and the means chosen to implement it/them. Pizon and Berger (Pizon & Berger, 2014) provide an example of an integrated school-based strategy in the field of addiction prevention. The authors recall the synergistic nature of the three pillars of the Downie, Fyfe and Tannahill model (education, prevention and protection). It should not be forgotten this combination of educational, preventive and protective

strategies is only productive if it totally makes sense in the social and cultural contexts in which it is developed, and if it respects these contexts as much as the people concerned (Balcou-Debussche & Rogers, 2015).

In this issue, this point is taken up in the article by Hrairi et al. which offers us an example of an educational strategy with a preventive aim. The author shows the importance of knowledge building in health education, but above all the need to take into account the socio-cultural context. Thus, in the Tunisian context where sex education is considered a taboo subject, the pedagogical stance (information vs. education) further deepens expectations between students and teaching. Thus, as just mentioned, the mere will for health education does not always guarantee the promotion of individual health.

Ben Hassine's article focuses, within health education itself, on communication techniques (interpersonal communication, cultural and intercultural communication, mass media, organizational communication, social marketing, training, advocacy, social mobilization...). Here again, the author emphasizes the importance of making a clear difference between the strategy adopted (in this case by the institution) and the intended objective. The context appears crucial. Coordination with regard to the players involved in the communication process as well as the involvement of the target population are indispensable.

### **Democracy in health and the collective construction of knowledge**

Let us continue with the second line of questioning raised in this issue: that of the power of the individual in the promotion of their own health, but also of their power to act for the community, that of the legitimacy of their knowledge in relation to so-called "expert" knowledge in the field of health. Health education, prevention and health promotion are political and public objects which give rise to multiple recommendations at all decision-making levels. Dahlgren and Whitehead pointed out the need to include health and equity in all policies and at all levels (Dahlgren & Whitehead, 1991; Dahlgren & Whitehead, 2007). The 1998 Bulletin Officiel de l'Education Nationale (the Official Bulletin of the French Ministry of Education) also states that health education "prepares young people to exercise their citizenship responsibly in a society where health issues are a major concern"<sup>3</sup>. These political recommendations are materialized at different levels of implementation and oscillate between individual and collective health objectives. The individual or collective nature of such issues

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<sup>3</sup> Orientations pour l'éducation à la santé à l'école et au collège. Circulaire n°98-237 du 24 novembre 1998 : Guidelines for Health Education in Primary and Secondary Schools in France which reaffirm the role of school in health education and proposes a number of ways to frame practices.

raises questions in terms of the place of individuals, their power to act and their role in the construction of knowledge. Health literacy, for example, is at the heart of the articulation between different epistemological stances (Balcou-Debussche, 2016): sometimes used as a tool for developing autonomy and strengthening the knowledge of an individual who is already an "expert" of their own health; sometimes formulated as an objective to transmit knowledge which was constructed without the individual who is considered as a "layperson".

This question of the citizen's role in the development of fair health policies built on solidarity focuses on the possibility to collectively develop (or not) knowledge, experiences and social transformations. Promoting democracy in health implies the articulation of "expert" and "lay" knowledge; each player is recognized whether a citizen/user/beneficiary or a professional, and has the legitimacy and power to act for themselves and for the community. We will first address this question in the light of the concept of "health democracy" (Tabuteau, 2014), which entails redistribution of power and, as Tabuteau points out, the "democratic elaboration of health priorities".

Demilly highlights the multiple meanings of the concept of democracy. She then states that, democracy is a legitimate expectation on the part of citizens on issues that concern them, health clearly being one of them (Demilly, 2014). As a reminder, the term "health democracy" appeared at the end of the 1990s, during the "Etats Généraux du cancer et de la santé" of 1998-1999. Lefeuvre and Ollivier specify that this concept is mainly manifested through the participation of public policy users in the institutional bodies which allow them to make themselves heard (Lefeuvre & Ollivier, 2018). As Domin reminds us, "the concept of health democracy was enshrined in the law on patients' rights and the quality of the health system (of March 4, 2002) and is reflected in a set of measures guaranteeing the individual and collective participation of users." (Domin, 2014, p22). Lefeuvre and Ollivier point to the difference between health democracy and democracy in health: the latter, according to them, integrates users' pathways which require decompartmentalized professional practices; the user is indeed an expert on their own life, their health, and their use of the healthcare system for example (Lefeuvre & Ollivier, 2018). Domin also distinguishes between health democracy, which makes citizen players capable of making decisions "on an equal footing" with professionals, and social democracy, which favours universality and equal access to the health system, for example (Domin, 2014, p22). Political decisions must involve the citizens they concern, citizen participation being essential in all areas of life (Demilly, 2014). Demilly even evokes the right of an individual and their relatives to speak up, and restores the citizen's full capacity as an expert. She emphasizes that this approaches also works to oppose all forms of discrimination or exclusion, drawing from the values of dignity and inclusive societies (Demilly, 2014). Callon, Lascoumes and Barthe suggest using "hybrid forums", which are spaces for debate open to all (Durand, Callon, Lascoumes, & Barthe, 2002), as well as

programmes that bring together experts and citizens (for the sake of clarity, let us make this distinction but remember that citizen and expert can be the same person), with a view to integrate the richness of diverse points of view in free debates contributing to the construction of a shared world (Domin, 2014).

We can recall here the words of Tovar, who states that "in classical social justice theories, the place of patients in the statement of equity criteria is either considered illegitimate (impartiality and adaptive preferences) or denied in its specificity (utilitarianism)" (Tovar, 2014, p68). The vision of democracy in health presented here is dissociated from any form of domination of a type of knowledge, and is in line with Demailly's postulate which invites co-creation to the table of a democracy in health that mobilizes the "lay expert" (Demailly, 2014, p6).

In this issue, Damus' article presents in a very subtle way the diversity of knowledge mobilized in breastfeeding in Haiti, analysing it as a complex construct of individual and collective social representations. The epistemological reflection on the necessary articulation between different types of knowledge, i.e. medical, experiential and cultural, reminds us of the importance to learn from models from other societies. Reflecting on the interactions between academic and patrimonial knowledge allows us to look at the relevance of practices within their social and cultural universes of reference in a different way, in Haiti, of course, but also beyond, including in western societies.

Tourette-Turgis also presents the need to rely on citizen knowledge, particularly in emerging or emergency situations with a deficit of medical knowledge (Tourette-Turgis, 2019). As an example, the deployment of "therapeutic activism" regarding AIDS was one of the main levers for the emergence of the concept of health democracy" (Tourette-Turgis, 2019, p 59). Lange and Victor refer to the democratic stakes relating to an investment in "educations to<sup>4</sup>" (Lange & Victor, 2006), which can promote the development of the reflective and critical skills needed to address socially acute questions (Legardez, 2004). Lange and Victor conclude that the issues raised by the concept of democracy in health include the status of experts (Lange & Victor, 2006), who are often professionals, but also researchers.

In this issue, Roelens proposes a critical and theoretical analysis of the ethical issues which link solidarity, citizenship and education (particularly health education) together, in the light of the field of political philosophy. Issues relating to equality and authority are at the heart of this article, which explores the links, contradictions, and articulations between approaches which combine the collective and the individual level. What ethical stances allow professionals to educate, cure and prevent?

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<sup>4</sup> in France the term "education to" is a generic term for cross-curricular subjects relating to health, citizenship and so on

Roelens' conclusion prioritizes minimal ethics as the resolution of this debate, conducted throughout this philosophical argument.

### **Inter-professionality and the reduction of health inequalities**

The design of health-promoting programmes is therefore essential to deploy social, educational and health policies at all decision-making and implementation levels. Such dynamics should be participatory and fair, and mobilise both citizens and professionals. The integration of the three-fold dimensions of education, prevention and protection aims to meet complex and growing individual and collective needs from an ecological perspective (Bronfenbrenner, 1977). This consideration of needs leads to the necessity to articulate a plurality of approaches and practices. Such complexity tends to constrain the sharing of a global and collective vision of implementation strategies (Berger, Pizon, Bencharif, & Jourdan, 2009; Simar & Jourdan, 2010). However, the mobilization of professionals from the health, education and social sectors in actual (vs tokenistic) collaborations and partnerships with citizens may guarantee appropriation of the programmes, and sustainable and fair efficiency (Deschesnes, Martin, & Hill, 2003; Samdal & Rowling, 2011). De Leeuw already pointed out the importance of intersectoral approaches in health promotion in 1989. At public policy level, all sectors are concerned, which subsequently materialises in all sectors of field practices, if a holistic meaning of health is envisaged (de Leeuw, 1989). Action on the determinants of health at the local level requires intersectoral collaborations which aim to develop social capacity, namely social cohesion and cooperation among members of a community (Hunter, Neiger, & West, 2011). It should be noted here the term "community" refers to the definition of the World Health Organization "Health Promotion Glossary"<sup>5</sup> (Nutbeam, 1999). Using the example of partnership practices between school-family and community, Deschesnes recalls the essential elements of intersectoral practices in health promotion: shared vision, positive climate, effective leadership, participatory decision-making processes, negotiation, and clear procedures (Deschesnes et al., 2003). Intersectoral collaborations, however, face difficulties. By presenting the case of partnership-type practices on addiction prevention in schools, Mérini and De Peretti offer some explanations (Mérini & De Peretti, 2002). The different

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<sup>5</sup> "A specific group of people, often living in a defined geographic area, who share a common culture, values and norms, are arranged in a social structure according to relationships which the community has developed over a period of time. Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them. "Health Promotion Glossary p 6

professional identities involved, and the diverse representations of the problems dealt with are as enriching as they are a source of potential difficulties in the negotiation process.

In this issue, Sivilotti's article thus underlines the stakes relating to disability support practices in higher education. The author shows that in addition to the representations of disability, professionals' representations of their role and the role of other professionals affect professional identity. Another essential point, which constitutes an additional obstacle to changing practices, is the lack of communication, co-construction and knowledge of the institution. The converging elements identified within various institutions and among various professions lead the author to reaffirm the importance of professional training, adapted to the requirements of practice.

### **What is at stake in terms of training?**

Considering training as a framework for supporting practices which respond to such complexity requires to root the development of professional skills in a dynamic, transdisciplinary and inter-professional continuum which draws from a diversity of collective knowledge. Professional health promotion practices are confronted with many points of variability: variability of contexts, conditions of practice, variability of the problems under consideration and of the processes underlying their genesis, variability of the strategies to be implemented, variability in the results to be hoped for as well as in their timescale. According to the CompHp framework, "a health promotion practitioner is defined as a person who works to promote health and reduce inequalities using the actions described in the Ottawa Charter (World Health Organization, 1986) (Dempsey, Barry, Battel-Kirk, & and the CompHp project partners, 2011, p3). As noted above, all professional sectors are concerned. Field professionals, whose missions have evolved towards integrating health promotion into their practices, as well as and new health promotion professionals, whose missions were created to respond to the growing demand and needs for integrated intersectoral practices are mobilized. Everyone does health promotion, with the risk that in the end, no one is actually doing it. It is thus crucial to ensure professionals share the values, theories, goals, and methods of the field of health promotion. However, disparities and heterogeneity in the training offer are to be deplored (Foucaud, Rostan, Moquet, & Fayard, 2006). Professionalisation is not envisaged in the same way for public health experts, health promotion experts, project managers, teachers, policy officers, general practitioners. This results in a very diverse range of activities (Dempsey, Barry, Battel-Kirk, CompHp Project Partners, 2011). Another challenge is to identify what constitutes the core of health promotion practices and the key competencies to be developed among professionals in light of the requirements of practices based on population needs, and not in terms of what policy prescribes or institutions expect (Atchison & al., 2004).

The article by L. Pinho de Mesquita Lago et al. proposed in this issue is rooted in the intersecting perspectives of two continents to explore the stakes of inter-professionality. The authors use an institutional socio-clinical approach to identify power relationships and implicit knowledge. The authors report on the fragmentation of the practices generated by institutional injunctions which "incite" different health professionals to work cooperatively. This research clearly illustrates trans-disciplinarity and inter-professionality are not self-evident. Relying on the history of professions and the construction of professional identities therefore seems to offer avenues to facilitate the process.

Furthermore, how can we define competence in health promotion? And what pedagogical stances should be favoured in order to develop such skills? Nagels proposes a definition of competence which seems to correspond to the constraints mentioned above. According to Nagels, competence is the "dynamics of social relations [in a company], sometimes considered as "a social construct" that "then combines individual and social value to become a process of attribution, of social judgement applied to performance and the outcome that results from it" (Nagels, 2009, p3). Competence would thus be socially constructed and accepted, which is similar to the preceding debate about the processes of knowledge construction. Competence in health promotion could therefore be defined jointly by professionals and users/beneficiaries of practice. Competence would gain from being dissociated from the out-of-the-field vision which can often be found in competency frameworks, as LeBoterf points out, adding that competence is constructed within the individuality and singularity of practices (Le Boterf, 2002).

Rossi's article proposes the experimentation of narrative medicine, a tool usually used by doctors to improve the relationship with their patients, with the training of all future health professionals. The author emphasizes the necessary evolution of the training of professionals, with a view to provide them with the skills to embrace the important role of end-users. According to Rossi, narrative medicine, which focuses on listening to the patient, allows future professionals to acquire new skills, to demonstrate reflexivity, but also to make changes in their attitudes.

## **Conclusion**

The stakes of this issue were to propose a critical reflection on the articulation between health education and prevention, from the perspective of health promotion, thus rooted in the principles of equity, citizenship and solidarity. The diversity of the contributions which were collected in this 13th issue of the journal *Education, Santé, Sociétés* does not exhaust the subject - far from it. However, this issue provides a space for the authors to question the theoretical models which underlie the design of strategies, as well as the models and approaches mobilized in the plurality of project and field actions,

each in their own way. The role of citizens, the conception, the articulation of knowledge are also in question, on the basis of a combination of research fields and epistemological stances with an underlying translational objective. The role of professionals, the construction and use of their knowledge is also reflected upon in the light of the training strategies aimed at promoting inter-professionalism and the mutualisation of diversified knowledge.

### **In Varia**

Verheye's article proposes to question the collaboration between patient-trainers and professionals during the implementation of therapeutic education programmes. Through an analysis based on grounded theory, the author proposes a systemic model of the characteristics of such "resource-patient" in terms of skills and motivation. The author also elicits the stakes related to the collaboration between patients and the professionals. Finally, the author proposes "demopraxis" in health as the operationalisation of carers' and patients' knowledge. This approach takes its roots in democracy in health, which involves the patient, in the author's words, as a generator or even a transformer of this approach.

The article by Vauthier et al. focuses on the strengths and weaknesses of the use of heuristic interview as a tool for educational professionals to collaborate with school partners, particularly through the improvement of their self-efficacy. The authors show training teachers in the use of this tool can modify their perceptions of the interview with parents. Indeed, they become significantly more aware of the importance of the physical attitude of their interlocutors as well as the importance to welcome the emotions they express. Here again, this research shows us the relevance of professional training for the implementation of the teacher-parent partnership, particularly through communication situations.

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