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Professionalisation of Estonian health promotion field: opportunities and obstacles in local governments for developing core competencies

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ABSTRACT

In response to global public health challenges and increasing demands for skilled practitioners, this study explores professionalisation and competency-based approaches among health promotion specialists in local governments in Estonia. The aim was to identify priority areas for competency enhancement and examine opportunities and barriers to additional training.

Semi-structured interviews with local government leaders (N = 10) and health promotion specialists (N = 9) were conducted. The sample consisted of interviewees recruited in 2022–2023 and represented three groups: local governments that had created or updated their health and well-being profile, those currently working on it, and those that had not yet begun updating the profile. Thematic analysis identified themes related to the role of health promotion specialists, training needs, awareness of learning opportunities, and the development of core competencies.

The findings revealed considerable variation in how the role of health promotion specialists is understood, alongside limited awareness of the competency framework guiding the profession. Key challenges included inconsistent role definitions, resource constraints, and uneven institutional support for training. Priority areas for competency development were identified in needs assessment, planning, evaluation, and communication. Major barriers to professional development included lack of time, funding, organisational support, and awareness of training opportunities, while employer encouragement, flexible learning formats, and perceived relevance to daily work emerged as important enabling factors.

Introduction

The public health workforce (PHW) is currently facing multiple challenges – the aftermath of COVID-19, global challenges, the climate crisis, and the war in Europe, to name a few. To tackle current and future challenges, a competent PHW is needed to evaluate health promotion policies and practices (Battel-Kirk et al. 2009; Mereu et al. 2015; Fattahi et al. 2020). Previous research has shown that there is already a growing need in the public health labour market, with respondents reporting that they believe the need for PHW with training in areas such as climate change may increase in the coming years (Krasna et al. 2020).

However, there is an ongoing discussion about what is needed for the PHW, including health promotion professionals (Meresman et al. 2006; Dempsey et al. 2011a). One solution proposed for capacity building and workforce development has been the identification of key competencies (Battel-Kirk et al. 2009, p. 12). The competency-based model has been widely used in health promotion practice, supported by professional standards and quality assurance systems. Reflection on the importance of this approach also clearly indicates input from a range of countries across the world (Van den Broucke 2017).

When discussing training needs, it is important to define the competencies. There are different definitions, but the overlapping elements are essential, such as knowledge, abilities, skills, attitudes, and values that are needed for professional practice (Battel-Kirk et al. 2009; Dempsey et al. 2011b, 2011c; Mereu et al. 2015; IUHPE 2016; PHANZ 2024). As Mereu et al. (2015, p. 35) explain, competencies are ‘the minimum sets of competencies that constitute a common baseline for all professional roles and are what all practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in a field’.

It is also debated whether competencies should be used as a basis for education and training (Battel-Kirk et al. 2009). Currently it has been agreed that this approach

is one of the pillars for the professionalisation of the PHW (Czabanowska and Middleton 2022). It is, however, important to ask ‘what competencies are specific to health promotion professionals?’ (Mereu et al. 2015), with different approaches being discussed in the literature. In addition, there is limited assessment of the impact of the competency-based approach on practice, teaching, and training (Battel-Kirk and Barry 2019).

Noting this, the competency-based approach is currently being used by health promotion specialists (Battel-Kirk et al. 2009; Czabanowska and Middleton 2022), which makes it possible for students, employers, and political decision makers to understand the expectations and basic values of the profession (Mereu et al. 2015, p. 35).

The health promotion competency framework has been developed at different levels: global (IUHPE 2016), regional (WHO/SEARO 2010; Dempsey et al. 2011c), and national (PHANZ 2024; Shephard et al. 2024), with most of the frameworks being developed by health promotion professional associations (Battel-Kirk and Barry 2019, p. 836).

When European WHO member states endorsed the competencies in 2012, it was highlighted that the core competencies should be taken into account in educational and training programmes at national and subnational levels (Mereu et al. 2015). In addition, the Helsinki Statement emphasises the importance of public health training, not only for specialists but also for other relevant professionals (e.g. journalists, civil servants, etc.) (WHO 2014, pp. 16–17).

For the professionalisation of the PHW, five levels are important: 1) competencies, 2) training and education, 3) formal organisation, 4) professional credentialing, and 5) code of ethics and professional conduct, together with taxonomy and enumeration (WHO 2022; Czabanowska et al. 2024). In the current article, we focus on issues related to training and education, keeping in mind the importance of other levels for professionalisation.

In the Estonian context where this study was carried out, the only curriculum that is accredited by the International Union for Health Promotion and Education (IUHPE) in 2014 is the curriculum of health promotion at Tallinn Health University of Applied Sciences (THUAS).¹ The competencies acquired in this curriculum are based on the health promotion specialist professional standard level 6 qualification approved by the Estonian Qualifications Authority (Kutsekoda 2024a). Core competencies, the professional standard, and accreditation were developed by IUHPE in the CompHP Project (2009–2012). The focus was on health promotion practice, education, and training for workforce capacity development (Battel-Kirk et al. 2015).

Estonia has aligned the core competencies for health promotion specialists with the international standard, incorporating nine of them into the professional qualification: (1) creation of preconditions and conditions for enabling health-promoting changes at the level of an individual, com-

munity, or society, (2) advocacy for health, (3) mediation through partnership, (4) communication, (5) leadership, (6) analysis of needs and resources, (7) planning of health-promoting activities, (8) implementation of health-promoting activities, and (9) evaluation and research. There is also competence across the profession, including engagement in life-long learning, up-to-date knowledge in health and community development, respect for diversity, following ethical and legal standards, effective communication in Estonian and a foreign language, and competent use of digital tools to support health promotion practice (Kutsekoda 2024b). In this study, when referring to competence across the profession, the authors specifically mean lifelong learning.

After graduation, students can apply for the professional qualification, which is issued by the Health Promotion Union of Estonia. They are currently a valid awarding body until 2029 (ETÜ 2013; Kutsekoda 2024a).

Estonia has defined the health promotion specialist as someone ‘with a degree in higher education and professional qualification, whose professional activities are geared towards the development of the health and quality of life of individuals, communities, organizations and the entire population. A health promotion specialist bases their professional activities on human rights and professional ethics. Their goal is to create equal opportunities and a supportive environment for different social groups to comprehensively develop their health potential and decrease social inequality in health.’ (Speller et al. 2012, p. 31).

Despite this well-defined qualification framework, several challenges remain in practice. The PHW in Estonia includes health promotion, disease prevention, and health protection, with these positions being shared with the health care sector (the health care sector focuses on one-to-one prevention, whereas health promotion focuses on population-level or specific group level prevention).

The positions where a specialist can work vary by field (prevention, promotion, welfare, health, public health, public safety, etc.) and by position (for example, in local government, ranging from a health promotion specialist to a specialist in social welfare, sports, and culture, or to a head of a unit with additional tasks related to health promotion). Previous studies show that more than half of the health promotion specialists’ main tasks are from another field (e.g. public health, public safety, social work, education, sports, culture, etc.), with only 32% of the respondents saying their main tasks are related to or mostly related to health promotion (Kookla and Purru 2024). In addition, there is a lack of qualified health promotion specialists in local governments, with 70% of the respondents indicating that they do not have professional education (Purru and Seema 2021). However, 80% of the respondents indicate that the specialist responsible for health promotion in local governments has participated in trainings for public health, health promotion, and public safety (ibid.). The occupational-level studies and additional

¹ There are, however, a few similar curricula at the University of Tartu and Tallinn University’s Haapsalu College. It is also possible to get additional training in prevention offered by the National Institute for Health Development. The training is based on the Universal Prevention Curriculum (TAI 2022).

study programmes are available for Estonian specialists, but there is a lack of overview about the match between specialist needs and available training opportunities (Kookla and Purru 2024).

Therefore, the aim of the research was to identify possibilities for enhancing the core competencies of health promotion specialists in local governments in Estonia through education, with attention to identifying priority areas for competency enhancement and evaluating the opportunities and barriers to additional training. Based on the aim, we identified the research questions as follows:

1. What are the knowledge and attitudes towards learning opportunities for acquiring health promotion core competencies in Estonian local governments?
2. Which core competencies need enhancement for specialists responsible for health promotion?
3. What are the opportunities or limitations for acquiring additional training in health promotion?

Materials and methods

For answering the research questions, a qualitative study with semi-structured interviews with leaders (10) and specialists (9) in local governments was carried out in 2022–2023. The interview questions were developed in collaboration with the National Institute for Health Development (NIHD) to ensure that they would effectively scaffold the interviewers' facilitation of the discussion, promote the optimal use of the allotted time, and support the generation of analytically meaningful, relevant, and information-rich data.

Some of the interview questions were tailored for the target group – the topic remained the same, but the focus of the question was adjusted. For example, the respondents were asked about their perception of the need for development in their professional competencies. The interviewer introduced nine competencies of a health promotion specialist and inquired which competencies they believed required development. Leaders were asked which competencies should be developed specifically in their field, while specialists were asked which of their personal competencies needed development. This question was asked from nine specialists and five leaders.

This study used a stratified sample. For creating the sample, all Estonian local governments (79 in total) were categorised into subgroups based on local government size, status of the health and well-being profile (HWP), health promotion specialist employment, and educational back-

ground (see Table 1). This created three groups of local governments:

- Group A – had recently created/updated their HWP,
- Group B – had begun updating/were currently working on an action plan,
- Group C – had neither updated nor begun updating their HWP.

Each local government was then assigned a randomly generated number, and the database was sorted based on the status of the HWP.

Secondly, it was ensured that the sample included both urban and primarily rural municipalities, large municipalities (>20 000 inhabitants), average-sized municipalities (10 000–20 000 inhabitants), and municipalities with fewer than 10 000 residents. Following a random pick from each stratum, the list of all municipalities was sorted using the previously mentioned background characteristics.

A larger pool of potential participants was initially selected for primary contact, taking into account the possibility of refusals, as participation in the study was voluntary.

The planned number of local governments was chosen at random from each stratum of the sorted database (A, B, and C in Table 1) in such a way that the other requirements for interviewees were met. Local governments with a health promotion specialist or a public health professional were preferred.

All interview invitations were sent individually. Participation invitations were initially delivered in written form, and, where necessary, follow-up contact was made by phone. In each local government that expressed willingness to participate, two interviews were arranged: one with the specialist and one with the leader.

During the course of the study, an additional sample was generated twice to ensure that the required number of participants was obtained from each stratum. Data saturation was reached in Group A by the identification of a change in the HWP status during the interview process with a Group B interviewee.

The interviews were given codes that included the stratum (A, B, or C), the interview's serial number, the position indicator (specialist or leader), and the survey code 'RPK' (indicating local government public health planning). For example, the code for respondent number 5, a local government leader in the B stratum is B_RPK-5-leader.

The collected data were analysed using a mixed method approach. For qualitative results, thematic analysis was performed with a focus on support mechanisms and obstacles

Table 1. Distribution of local governments and planned in-depth interviews

Status of health and well-being profile (HWP)	Total number of local governments	Actual quantity of interviews with local government leaders/specialists conducted
A. Created or recently updated their HWP	max 18	8 interviews
B. HWP under development or currently creating an action plan based on it	max 13	3 interviews
C. Not complied or has not been updated recently	48	8 interviews
Total	79	19 interviews (incl. 10 leaders and 9 specialists)

Table 2. Connection between research questions and analysed themes

Research question	Theme
RQ1. What are the knowledge and attitudes towards learning opportunities for acquiring health promotion core competencies in Estonian local governments?	1. Importance of professional training for health promotion specialists 2. Role of the health promotion specialist 3. Awareness of learning opportunities 4. Attitudes towards health promotion
RQ2. Which core competencies need enhancement for specialists responsible for health promotion?	5. Awareness of core competencies 6. Necessity of developing core competencies
RQ3. What are the opportunities or limitations for acquiring additional training in health promotion?	7. Supporting and/or hindering factors in combining study and work

related to the core competencies of a health promotion specialist. Thematic analysis was preferred as this involves categorising the text according to the themes that have arisen and then analysing it in accordance with the research questions. The analysis does not concentrate on counting words; rather, it uses this technique to split statements with related meanings into distinct themes (Ezzy 2002). The initial coding was done using MAXQDA (VERBI Software, Germany). Two coders worked on the material, with one coder doing the initial coding, followed by revision and discussion by the second coder. The analysis was written together by two coders simultaneously.

The final coding tree for the project included 10 main themes (see the coding tree in Appendix), but in the current article, we focus on the themes that are related to training and learning core competencies for health promotion (see Table 2). Table 2 illustrates how the research questions were examined through the thematic analysis. The themes linked to RQ1 capture both cognitive and normative dimensions of learning, including understanding of the specialist's role, the perceived importance of professional training, awareness of learning opportunities, and broader attitudes towards health promotion. RQ2 focuses more narrowly on professional self-understanding, addressing both the awareness of formal core competencies and perceptions of the need to further develop them. In contrast, RQ3 shifts the focus from individual competencies to conditions that support or limit participation in education. Overall, the themes reflect a progression from individual views to broader factors that influence learning and professional development in local governments.

Based on the discussion of the codes, a small element of quantitative content analysis was conducted to make recurring patterns in perceived development needs visible, to allow comparison across core competencies, and to support interpretation of the qualitative findings by indicating how often different competencies were mentioned as requiring or not requiring additional development. This approach helped clarify which competencies were consistently emphasised across interviews and which reflected more individual or context-specific perspectives.

Ethical considerations

Although this study did not require ethics committee approval in Estonia, there are several ethical considerations relevant to this research. Informed consent was sought, which the

participants signed digitally. The respondent was reminded of the study's objectives, methods, and right to decline participation before the interview began. The respondent had the option to decline an interview at any point throughout the study or request more information about the applicable study's content, the respondent's rights, data protection, or technical setup. The interviews were held and recorded online (via Zoom), and pseudonymised transcriptions were created following the interviews.

To prevent the possibility of personal identification after the interviews, the transcriptions were done as soon as possible, and each file was assigned a subject-specific code consisting of the stratum, interview's serial number, the position (specialist or leader), and the survey code.

Informed consent forms, interview recordings, and transcriptions were all stored on a secure server accessible only to the research team working on the analysis.

The members of the research team collaborated as a cohesive team, sharing responsibilities and performing a range of specialised tasks. For example, during data collection, the initial contact with potential participating local governments was made by the NIHD. Data collection was carried out by students.

Results

Knowledge and attitudes towards acquiring core competencies

The knowledge and attitudes towards learning opportunities for acquiring health promotion core competencies in Estonian local governments are related to understanding the role of the health promotion specialist, understanding the importance of professional training for them, as well as awareness of learning opportunities.

In understanding the role of the health promotion specialist – who they are as professionals and how their work aligns with the tasks of the local government – the leaders and specialists expressed different opinions.

Respondents in Group C (both those in leadership roles and those in specialist roles) found it difficult to describe the role of a health promotion specialist – they were unsure of who they are or what they do:

'Honestly, I don't have an answer to that.' (C_RPK-9-leader)

Conversely, Group A had a clear understanding of the role and responsibilities of a health promotion specialist. They

emphasised that this professional's goal is the systematic improvement of public health within their area (for example, within a local government):

'It's a person ... or an employee who ensures that the institution or organisation they work for takes systematic steps to address public health issues. This includes prioritising public health topics and creating specific plans and activities to improve public health.' (A_RPK-7-specialist)

There was variability among respondents regarding who a health promotion specialist is and what their responsibilities might include. A highly critical view perceived the role as merely generating 'hot air' and spending resources, while a more neutral perspective reflected uncertainty about who health promotion specialists are and what they are expected to do. Positive descriptions of a health promotion specialist were tied to real-life experiences of how they perform their work in local governments or regions.

The tasks of a health promotion specialist were also seen as need-based, depending on specific priorities and assignments that might arise from their targeted work. For example, tasks related to the HWP help define local needs and priorities, which can then be included in the annual action plan. In addition, respondents noted that such a position could only be established in larger municipalities, as in smaller municipalities this role either does not exist or is carried out by a part-time specialist. This is also related to the fact that their goals can be approached through various fields – be it culture, sports, health, or well-being, especially in smaller municipalities. Within a systematic approach, it was noted that a health promotion specialist can use HWPs to identify the challenges within a sector or region and to set objectives by determining what should be addressed and through which actions within the planned timeframe.

According to the interviewees, it is necessary for a health promotion specialist to have professional education. They noted that, on the one hand, being an active person is not enough, as basic knowledge is also required. On the other hand, a health promotion specialist must be familiar with the fundamentals of what works and what does not work at the population level.

However, questions arose regarding the level at which specialised education is necessary. Is it needed in small local governments with populations of 5000, or is it more relevant to larger municipalities? Alternatively, should a specialist with professional training be present at least at the county level:

'I think so, yes /.../ expecting that all municipalities equally have someone for this role is probably unrealistic, as not all have the capacity, nor is it necessary. But at the county level, it may indeed be appropriate.' (C_RPK-19-leader)

It was also suggested that if a specialist does not have specific training in health promotion, their background should not be too different from the field (e.g. construction specialist or lawyer). Instead, they should come from a related discipline with overlapping competencies, such as education, social work, or medicine:

'The person should have some basic education, preferably higher education /.../ they cannot be, for example, a lawyer

or a construction specialist. The field should somehow support this role, whether they have a medical background or at least a social work background, or something similar – something at least tangentially related. Or they could be a teacher, for example.' (A_RPK-1-leader)

Awareness among professionals in the field about where to acquire the competencies needed for a health promotion specialist varies widely. Responses ranged from not knowing where such competencies can be obtained to the belief that these competencies cannot be acquired anywhere, and to identifying various institutions and programmes involved in training health promotion specialists. Different institutions offering formal education were mentioned (Tallinn Health University of Applied Sciences, Tallinn University's Haapsalu College) as well as those providing additional education (the Association of Municipalities and the NIHD). Additionally, it was suggested that the core competencies outlined in the qualification standard could be acquired through specific courses if needed:

'... but perhaps somehow /.../ just to check that box and maybe participate in individual courses as needed.' (A_RPK-15-leader)

While some specialists are aware of formal and additional education opportunities for acquiring health promotion competencies, others remain uncertain or sceptical about where and how these competencies can be obtained. This highlights the need for clearer communication and accessibility of training pathways.

Enhancement of core competencies

The results of the interviews showed limited knowledge of the core competencies. For example, none of the interviewed local government leaders could name a single core competence:

'No, I must admit that I can only guess about such things; I don't know what those nine competencies are. I'm not familiar with the qualification standard.' (A_RPK-1-leader)

Three out of eight specialists were unable to name any competencies. Each competency was mentioned at least once by some respondents. The most frequently mentioned competencies were collaboration and planning of health-promoting activities:

'Well, it's definitely a field where you need to do a lot of collaboration and partnership. /.../ I really can't say what those competencies are supposed to be.' (A_RPK-13-specialist)

To further explore perceptions of professional development needs, respondents were introduced to the core competencies of health promotion specialists and asked to reflect on which competencies required additional development and which they felt confident in. Table 3 summarises the frequency with which individual competencies were mentioned by specialists and leaders in local governments. The frequencies reflect how often competencies were discussed and should be interpreted as indicative of perceived relevance rather than as objective measures of competence.

Overall, Table 3 reveals a clear distinction between competencies that are primarily developed through everyday professional practice and those that respondents associate with formal training. Specialists most frequently identified

Table 3. Health promotion specialist's core competencies that do/do not require development according to the opinions of local government specialists and leaders

Core competencies	Mentioned by specialists		Mentioned by leaders	
	Requires development	Feels confident in	Requires development	Does not require development
A.2.1 Enable change	2	1		
A.2.2 Advocate for health	3	1		
A.2.3 Partnership		7	2	
A.2.4 Communication	5	2	1	
A.2.5 Leadership	1	2	1	
A.2.6 Assessment of needs and resources	6	1		
A.2.7 Planning	6	1		1
A.2.8 Implementation	4	2		1
A.2.9 Evaluation and research	5	1	1	
A.2.10 Competence across the profession: lifelong learning	3		2	

assessment of needs and resources, planning, implementation, and evaluation and research as areas requiring further development, suggesting perceived gaps in analytical and strategic competencies. In contrast, partnership was the only competence in which specialists consistently reported confidence, indicating that collaborative skills are largely acquired through practical work. Leaders, however, referred to a narrower range of competencies and tended to frame development needs at the organisational level rather than in relation to individual professional roles. The limited attention paid by leaders to competencies such as advocacy for health or assessment of needs and resources reflects their lower familiarity with the competency framework and reinforces earlier findings regarding limited awareness of the qualification standard. The different perspectives of specialists and leaders point to a misalignment between professional development needs and managerial expectations in local governments. While specialists emphasised the need to strengthen competencies related to evidence-based planning and evaluation, leaders prioritised more general, transferable skills, such as communication and leadership, and did not perceive a need to further develop planning and implementation competencies. This difference in perspectives may influence how training needs are recognised, supported, and prioritised within local governments.

In addition, in terms of communication, there is a desire to learn more about marketing and its specifics. Specialists also mentioned the competence across the profession multiple times, emphasising the need for lifelong learning, as all health promotion specialist's competencies are important and require continuous development and improvement:

'... I can't imagine that at some point one becomes a fully developed health promotion specialist, in the sense that perspectives constantly change, new research studies emerge, and new findings come out /.../ every day brings new opportunities for growth...' (A_RPK-14-specialist)

Additionally, it was highlighted that core competencies are important for every public official and should be further developed. It was also acknowledged that some of these competencies are acquired during university studies, even in other fields, as well as through additional education and training programmes:

'... I think that at least half of these competencies can be acquired through some other form of education, or through additional training, or through previous work experience /.../ These competencies are the ones that every good public official should actually possess...' (A_RPK-13-specialist)

Advocacy for health was mentioned in different contexts: as a competence that needed development and as a competence they were professionally engaged with and felt confident in. None of the specialists mentioned partnership as something they would like to develop in themselves. In addition, leadership and enabling health-supporting changes were also identified by respondents as competencies that do not require additional training. Most interviewees felt confident in the competencies they had encountered in their professional work. Additionally, while there was no direct need to enhance their knowledge – since all necessary information could be found if needed – they still expressed interest in further training on very specific topics that would help them solve current issues:

'... I can't say that there's anything I struggle with. I haven't really noticed such an area at the moment. Rather, if there's a problem, you research it and figure it out for yourself...' (B_RPK-4-specialist)

While specialists were interested in practical skills, leaders wanted to develop universal skills in their field, such as communication, partnership, leadership, and evaluation and research:

'It seems to me that we are quite good at planning and implementing activities. Maybe evaluation and research need more development... /.../ and possibly leadership as well.' (C_RPK-18-leader)

According to leaders, the core competencies that do not require development in local governments are the planning and implementation of health-promoting activities. Leaders did not mention competencies such as advocacy for health, enabling health-supporting changes, and assessment of needs and resources at all. What leaders did mention was the competence across the profession – lifelong learning. Both specialists and leaders emphasised the value of regular professional development and the need to keep strengthening all core competencies.

It was, however, noted that if the expectations for competencies in the position are set too high, it becomes difficult to find a suitable specialist for the role:

‘... I’m just afraid that, knowing all the other fields as well, at the end of the day, if the requirements are set too high, you might not find these people...’ (A_RPK-1-leader)

In summary, although the formal education for a health promotion specialist is based on the professional standard, the local governments and specialists in the field have limited knowledge of the core competencies and their relevance to the professional requirements.

In addition, there was a discrepancy between what the leaders saw in the development in the field and what the specialists saw as what they needed in the development of their core competencies. Specialists indicated that there was a need for the development of competencies in assessment of needs and resources, evaluation and research, planning and implementation of health promotion activities, and communication.

Leaders, on the other hand, highlighted the need to advance the universal competencies in the field (communication, partnership, evaluation and research) of which the partnership was assessed sufficient for specialists. They did not see the need to advance the competencies of planning and implementation that specialists, on the other hand, emphasised as a need. What both the leaders and the specialists agreed on was the need to develop competencies across the profession, specifically lifelong learning.

Supporting and/or hindering factors in combining studies and work

In terms of participating in continuous education and additional training, the interviewees highlighted various factors that could either support or hinder learning, noting that the same factors could be perceived as both supportive and restrictive, depending on the perspective. The following factors were identified in relation to balancing studies and work: perceived necessity, flexibility, cost, location, time, personal motivation, workplace support, external motivation, accessibility of information, national policy, and the shortage of specialists.

Both health promotion specialists and local government leaders highlighted that the decision to pursue education (whether through formal or additional education) is supported by the learner’s perception of the relevance of the studies to their daily work. They emphasised that when individuals see that the acquired information, contacts, or experience can be

practically applied in their everyday tasks, it makes their work easier and encourages them to engage in learning:

‘I think, first of all, they should know what they need, whether they need it, and also have the willingness to develop themselves.’ (A_RPK-11-specialist)

The flexibility of studies was also highlighted as a factor that facilitates participation in education, allowing learners to fit their studies around other responsibilities. Flexibility was understood both in terms of a flexible study schedule and the ability to participate in a flexible manner, for example, being able to miss a (learning) session without disrupting the learning process or attending via hybrid learning options online. Conversely, it was noted that if education is not flexible, the likelihood of enrolling decreases. This aspect was emphasised in relation to both formal education and additional education.

According to the respondents, the cost of education also plays a role in participation – whether the training is free or paid and, if paid, who covers the expenses. When training is free, it is easier for specialists to participate, as they do not have to figure out how to finance their studies. Likewise, it is easier for leaders to allow specialists to attend training sessions:

‘... if it’s free, then you can attend trainings from morning till evening...’ (A_RPK-11-specialist)

It was also noted that in the case of paid training, if both the specialist and the leader consider that the training is valuable and beneficial for daily work, resources for it are often already planned in the budget. However, this requires a local government that is willing to support its employees and, at the same time, has sufficient resources to do so in the described manner.

The importance of time resources for participation in education was also highlighted. Respondents considered all their responsibilities, including work-related, volunteer, and family obligations when assessing whether they had enough time left for studying. A key point emphasised was that work tasks must still be completed:

‘... I have a very good employer /.../ if my work tasks are completed, I’m sure I can find a free moment, time, and resources for studying.’ (C_RPK-8-specialist)

On the other hand, it was emphasised that if there is no time left alongside work, i.e. if work consumes all available time, it becomes difficult to participate in education or even consider it. Work overload was highlighted in cases where employees could not even schedule vacation days because, in addition to their own duties, they had to cover for colleagues on leave. This was described as a paradox of the public sector, where services must always remain accessible to people:

‘Well, that’s it, it’s mainly the time, the resource, you don’t have /.../ one specialist has to replace the other /.../ Public sector is rather poor in that sense because you have to be public and available all the time...’ (B_RPK-4-specialist)

It was pointed out that education itself is time-consuming – even if studying takes only one to two days a week, it creates a gap in work that has to be made up the following week. This leads to tasks piling up, and planning work becomes very difficult:

'... the next three days are spent catching up on the time you've been in school...' (A_RPK-13-specialist)

In addition to work life, other obligations and aspects of personal life also play a role in evaluating time resources. When other life responsibilities interfere with work (e.g. young children are often sick), it becomes difficult to find time for studying. The timing of training and education was also highlighted as these tend to be seasonal, but it would be beneficial if they were offered during other times, such as in summer.

The interviewees concluded that the motivation to learn must come from within the individual. If personal motivation to learn is lacking, it is very difficult for the employer to support the learning process:

'A person can only learn if they are motivated. If they lack that motivation, no matter the reasons – whether it's laziness or the belief that they already have all the knowledge – they might talk about it, but they still won't go...' (B_RPK-5-leader)

Both the leaders and specialists pointed out that support from the employer is helpful for different types of studies. Employer support can mean various things, such as planning studies into the budget, maintaining the salary during studies (where studies become part of the work tasks), providing study leave, and ensuring that work tasks allow time for learning: *'Well, certainly, if the learning is enabled, even partially during working hours, because if it's in the field you work in, then definitely in this way, because otherwise, we would just wear the person out without any rest days or time off. Well, certainly, as much as possible, try to maintain the salary during that time.'* (C_RPK-17-specialist)

Employer support can also be moral, in the sense that they do not hinder a motivated employee from participating in studies, or they actively encourage the specialist to take time for learning. It was also pointed out that the employer can be flexible when managing training volumes – if additional training is needed, the employer will find a way to accommodate it (in terms of time and finances).

The employer can also be a hindering factor – if they prioritise filling work hours during the working day or do not see the need for the specialist to participate in training or studies. A hindering factor was also mentioned when the employer supports participation in training and education but does not make the necessary organisational changes to enable the employee to participate in the learning process:

'But what definitely hinders is the overload, it's a really significant obstacle. If a person is busy from morning till evening with their same work or tasks, and they can't get them done directly, then they start thinking, when am I going to attend that training...' (A_RPK-1-leader)

A supportive factor mentioned was external motivation – that the team or group spirit encourages participation. On their own, a person might lack motivation, but collaboration with others and participating in the learning process together helps maintain the learner's own motivation. At the same time, it was also pointed out that additional compensation or rewards can also encourage participation in studies (and their completion):

'Yes, unfortunately, it's still the case that money is a motivator. If you say that you'll get this education or that by completing it you'll receive a performance bonus or a salary increase, that's what motivates people...' (A_RPK-3-leader)

External motivation also includes the question of whether training or education should be mandatory. Opinions on this were divided. On the one hand, it was argued that making training mandatory encourages participation, especially if the requirement is supported by an important organisation in the field. On the other hand, it was pointed out that making training mandatory can hinder participation – more specifically, it can reduce engagement with the content being taught, especially if the individual is not personally willing or ready to participate.

Participation in training or education is also encouraged when information about the training or study opportunities is accessible or has reached the specific local government. Interviewees mentioned that they are often unaware of relevant training and educational opportunities and do not know where to look for them. On the other hand, the availability of information supports learning, as it allows individuals to stay up to date with essential work-related developments and resources.

It was also highlighted that national policy itself should support additional education and participation in training, as local government activities are always linked to national policy. If national policy is favourable towards local government operations, the local government is more motivated to implement relevant activities. The same applies to the field of training and participation in education:

'The general national policy should also support this whole principle, as it makes it easier for the local government to reach people.' (A_RPK-10-leader)

A prerequisite for participating in training and education is the availability of relevant specialists. However, from the perspective of the local government, a concern was raised that there are no specialists to hire – if there were, the local government would gladly support their education, but if specialists cannot be found, there is no one to support:

'If there were someone to train, of course, we would train them, we would send them somewhere all the time...' (C_RPK-2-leader)

Successful learning depends on a combination of personal motivation, practical applicability, and systemic support. Addressing these factors holistically can improve participation in education and professional development within the public sector.

Discussion

The current research focused on the professionalisation of Estonian health promotion field and looked at the opportunities and obstacles for enhancing health promotion specialists' core competencies. The results based on the semi-structured interviews carried out with leaders and specialists in Estonian local governments highlight that despite the health promotion specialist professional standard, there is a variety of opinions about who the health promotion spe-

specialists are and what their responsibilities include. This result is in line with previous research carried out in the same setting (Kookla and Purru 2024). If the profession is not clearly understood, there is also limited understanding of the core competencies and of the knowledge and attitudes related to their learning opportunities. Similar results have also been noted by Battel-Kirk and Sendall (2022), indicating that this is not only a local issue in Estonia but part of an internal discussion within the health promotion profession at the global level.

Local governments who presented positive experiences with health promotion specialists also shared experiences in using the HWP as a tool to identify challenges in the region or in the sector and to assess where the effort should be targeted. This indicates that the competency-based approach proposed by Battel-Kirk et al. (2009) is seen as beneficial to Estonian local governments in planning their work.

It was also highlighted that a health promotion specialist's role can be filled by someone with similar education – for example, from culture, sports, health, or well-being – with the expectation of acquiring the additional training and advancing the competencies needed. This was not considered to be an ideal situation, as the respondents did indicate the professional education in health promotion to be essential for the role, but this was seen as a possibility for smaller areas and local governments that have fewer resources. This finding also supports the competency-based approach to health promotion specialists, as the development of the competencies is not reserved only for them but could also be developed by other comparable professions, as noted by Mereau et al. (2015).

Although the respondents highlighted the need for professional education, there was limited awareness of what the core competencies are, how they are related to the professional standard for the health promotion specialists and where and how the core competencies can be acquired or advanced. More work needs to be done in Estonia to build workforce capacity, as highlighted in the Helsinki Statement (WHO 2014).

The need for PHW to be equipped with necessary information and competencies for their work has been highlighted in the literature, specifying that these competencies must include skills to detect disadvantage as well as skills to get an overview of factors determining citizens' health (Hagen et al. 2018). Moreover, the role of PHW and their professionalisation is crucial, as in their executive role they are key players in planning processes across municipal sectors (Fosse and Helgesen 2015). Our results show that leaders and specialists in local governments have different opinions about which core competencies need enhancement. Leaders and specialists disagree regarding competencies of partnership (leaders see this as a need, while specialists have the opposite opinion) and planning and implementation (specialists see this as a need, while leaders do not). Both agree on the need to enhance the competencies of communication, evaluation and research, and competencies across the profession (specifically lifelong learning). Specialists also highlighted the need to enhance the competencies related to assessment of

needs and resources. It is important to mention that the development of the competence related to lifelong learning requires continuous improvement and regular professional growth, as new and emerging issues and health promotion principles such as sustainability and equity are becoming more relevant than ever (Saboga-Nunes et al. 2020).

The difference between the perspectives of leaders and health promotion specialists indicates challenges in providing additional training because support from the leader is needed. This raises the question of how to achieve the support for the competencies where there is a difference in opinion.

The latter point is important, as for additional training, it was highlighted that the factors supporting it are a combination of personal motivation, practical applicability, and systemic support. Differences in opinion might hinder systemic support from the local government. Additional trainings therefore need to address these factors holistically in order to improve the participation of the PHW in the public sector. The same issue exists also in the field of prevention training and education, which varies greatly in Europe (Gabrhelik et al. 2015) and makes it more complex to focus on the role of a specialist.

There was also a difference in opinion between Group A (HWP recently created or updated) and Group C (HWP not created or not updated). For Group C, it was difficult to explain how they understood the role of a health promotion specialist and how this position could be useful to the local government. On the other hand, respondents from Group A provided exact and specific justifications reflecting a clear understanding of the role and responsibilities of a health promotion specialist and how they are seen as a resource for the local government.

Additional training for health promotion specialists could, in the Estonian context, focus on the mixing of disciplines and different capacities, incorporating the training into the work of other relevant professionals, as highlighted by the Helsinki Statement (WHO 2014). This could also raise awareness among employers and political decision makers about the values and expectations relevant to the health promotion specialists, as highlighted by Mereu et al. (2015). There is a need for flexible educational pathways that allow professionals with related backgrounds to systematically build health promotion competencies. Learning formats that are short, practice-oriented, and easy to integrate into working life could be offered. For the health promotion curriculum in Estonia, the focus should be turned more towards assessing the impact of competency-based approach to teaching and training (Battel-Kirk and Barry 2019). Given the renewal of the curriculum in 2025, learners' journeys could be mapped and analysed.

As the results indicate, there is a continuing need for a clearer definition of the role of the health promotion specialist among leaders, specialists, and the wider public. The findings are useful for developing and designing additional study programmes and for supporting participation in future training to meet the needs of local government specialists. In comparison with global development practices, it can be suggested that the competency-based training model for health

promotion remains a relevant and potentially sustainable approach for the future.

Limitations

A limitation of this study is the absence of participation from local governments in the north-eastern region of Estonia. Despite invitations sent to municipalities in this area, none agreed to take part in the research. As a result, the findings may not fully capture the regional diversity of perspectives and experiences related to health promotion competencies across the country. This limits the generalisability of the results to the north-eastern context.

During data collection, it became apparent while conducting one Group B interview that the local government had already prepared the HWP in the interim period. As a result, the interviewee initially invited as part of Group B was identified during the interview as a representative of Group A, and the planned number of interviews was adjusted accordingly.

Conclusion

This research shows that the respondents often struggled to describe the role of the health promotion specialist, were only vaguely aware of related competencies, and were uncertain or sceptical about where and how these competencies could be obtained. In these settings, health promotion was less frequently framed as a strategic contribution to local development and more often as an add-on to other responsibilities. In local governments with practical experiences of systematic health promotion work (development and use of HWP), both leaders and specialists described the role more clearly, articulated specific needs, and tended to value health promotion as an important lever for addressing local problems and guiding local development.

Leaders and specialists differed in which specific competencies they considered most in need of development. Specialists emphasised the full cycle of assessing needs and resources, planning, implementation and evaluation, as well as communication competences, whereas leaders more often highlighted universal skills, such as communication, partnership, and evaluation and research.

Both leaders and specialists stressed that participation in further education was realistic and meaningful mainly when learning opportunities were flexible in timing and mode of delivery, clearly linked to their everyday work tasks and supported by their employer in terms of time and funding.

Data availability statement

Data supporting this study cannot be made available due to ethical reasons, as confidentiality was promised to the interviewees.

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Appendix. Coding tree for thematic analysis

1. Importance of professional training for health promotion specialist
2. Role of health promotion specialist
3. Awareness of learning opportunities
4. Attitudes towards health promotion field
 - 4.1. Leaders' role in shaping attitudes towards health promotion
5. Awareness of core competencies
 - 5.1. Awareness of occupational qualification standard
6. Necessity of developing core competencies
7. Supporting and/or hindering factors in combining study and work
 - 7.1. Perceived necessity
 - 7.2. Flexibility of studies
 - 7.3. Cost of studies
 - 7.4. Location of studies
 - 7.5. Timing of studies
 - 7.6. Learner's time resources
 - 7.7. Personal motivation
 - 7.8. Workplace support
 - 7.9. External motivation
 - 7.10. Accessibility of information about studies
 - 7.11. Mandatory requirements
 - 7.12. National policy of studies
 - 7.13. Presence of specialists
 - 7.14. Shortage of specialists
8. Status of HWP
9. Supporting and/or hindering factors in developing and using HWP
 - 9.1. Mandatory requirements
 - 9.2. Employees and communication
 - 9.3. Support from the National Institute for Health Development
 - 9.4. Team trainings
 - 9.5. Availability of data
 - 9.6. Attitudes towards the purpose of HWP
 - 9.7. Prior experience
 - 9.8. Time resources
 - 9.9. Personal motivation
 - 9.10. Financial resources
 - 9.11. Human resources
 - 9.12. Integration into planning processes
10. Strategic planning in the local government
 - 10.1. Recognizing the potential of HWP
 - 10.2. Use of HWP in practice
 - 10.3. Mandatory requirements
 - 10.4. Needs-based planning
 - 10.5. Development plan as the key guiding document
 - 10.6. HWP as part of strategic planning process

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Eesti tervisedenduse valdkonna professionaalsemaks muutmine: kohalike omavalitsuste võimalused ja takistused kompetentsi arendamisel

Liina Riisenberg, Mari-Liisa Parder, Jelizaveta-Anna Viikmann ja Nele Kunder

Artikkel keskendub tervisedenduse spetsialistide professionaalsele arengule Eestis; fookuses on kompetentsipõhine lähenemisviis. Eesmärk on välja selgitada kohalike omavalitsuste juhtide ja spetsialistide hoiakud, vajadused ja võimalused tervisedenduse kompetentside arendamisel. Käsitlust leiavad teemad, mis on seotud tervisedenduse spetsialisti rolli, tervisedendaja kutsestandardist tulenevate kohustuslike kompetentside ning erialase taseme- ja täienduskoolituse olulisuse, vajaduste ja võimalustega ning nende omandamist toetavate ja takistavate teguritega. Andmete kogumiseks viidi läbi 19 poolstruktureeritud intervjuud, neist kümme omavalitsusjuhtide ja üheksa omavalitsuses töötavate ning rahvatervishoiu valdkonna eest vastutavate spetsialistidega. Tulemused näitavad, et tervisedendaja rolli mõistetakse erinevalt ja teadlikkus kompetentsidest on piiratud. Kompetentsidest vajavad arendamist näiteks vajaduste hindamine, planeerimine ja kommunikatsioon. Tasemeõppesse ja täienduskoolitusele suundumist takistavad muu hulgas ajapuudus, puudulik rahastus ja tööandja tugi ning vähesed teadmised õppimisvõimalustest. Mõned toetavad tegurid on näiteks paindlikud õppevormid ning õppe- ja tööülesannete ühildamise võimalus. Edaspidi on vaja selgemaid rollimääratlusi, tööjõu strateegilist planeerimist ja kestlikku panust professionaalsesse arengusse.
