

**Review Article**

## Health Promotion: Lecture Course Materials for Master's Students

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**Abstract:** Health promotion has now become a major field of reflection and intervention within public health. It reflects a gradual shift from an essentially biomedical conception of health towards a comprehensive approach that takes into account the social, economic, cultural, political and environmental dimensions of health and illness processes. This course offers a sociological perspective on health promotion, considering it not merely as a technical approach to health intervention, but as a social, institutional, political and relational process. In particular, it seeks to understand how material living conditions, social positions, power relations, available resources and collective representations contribute to producing differentiated health outcomes. The course is organised around four complementary areas: the conceptual and ethical foundations of health promotion; the actors involved and institutional dynamics; the social, economic and environmental determinants of health; and, finally, intervention methodologies and strategies. Particular attention is given to empowerment, community participation, health democracy, intersectoral collaboration and action research. The overarching pedagogical aim is to enable students to understand the social mechanisms underlying the production of health inequalities and to develop the critical capacity required to analyse, design and evaluate health promotion policies and interventions.

**Keywords:** Health Promotion, Sociology of Health, Prevention, Empowerment, Social Determinants, Health Inequalities, Community Participation, Health Democracy, Public Policy.

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## INTRODUCTION

Health constitutes one of the key domains in which contemporary transformations in the relationships between individuals, institutions and society can be observed. For a long time, understandings of illness were largely dominated by the biomedical paradigm, which tends to privilege the biological and pathophysiological dimensions of health problems. From this perspective, intervention consists primarily in diagnosing, treating and, to a certain extent, preventing disease.

Yet the evolution of contemporary societies demonstrates that health problems cannot be explained solely through biological mechanisms. Housing conditions, income levels, education, employment, the environment, dietary practices, gender relations, social networks, working conditions and access to health resources all contribute to the production of health outcomes. Pandemics, chronic diseases, mental health problems, environmental risks and inequalities in access to healthcare have therefore progressively shifted the

analytical focus away from disease towards the social conditions under which health is produced.

This shift has accompanied the emergence of health promotion as a new orientation in health action. In this regard, the Ottawa Charter of 1986 represents a seminal moment. It defines health promotion as a process that enables populations to increase their capacity to exercise control over the determinants of their health. Health consequently ceases to be understood solely as the outcome of professional intervention and increasingly comes to be regarded as a collective resource and an object of civic participation.

Such a conception entails a transformation in the relationship between institutions and populations. The patient or service user is no longer viewed merely as the recipient of an intervention designed and implemented by professionals; rather, they may become an actor, partner and co-producer of health action. This transformation nevertheless raises fundamental questions concerning the power relations that structure

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the health field: who defines needs? Who possesses legitimate knowledge? Who determines priorities? Who has access to the resources required for action? And to what extent does population participation constitute a genuine redistribution of power?

A sociological approach provides precisely the analytical tools required to interrogate these dimensions. It conceptualises health as a social fact, that is, as a reality embedded within social relations, institutions, norms and structures of power. From this perspective, promoting health does not merely involve disseminating information or modifying individual behaviours; it also entails addressing the social conditions that render certain populations more exposed to health risks than others.

The present course therefore pursues a dual objective. On the one hand, it seeks to provide students with a robust conceptual understanding of the foundations of health promotion; on the other, it aims to equip them with sociological analytical tools through which to examine contemporary public health practices, policies and institutional arrangements.

## **Chapter 1 – Conceptual and Ethical Foundations of Health Promotion**

### **1.1 Understanding the Concept of Health Promotion**

Health promotion refers to an approach to health action that seeks to strengthen the capacity of individuals and groups to act upon the factors that shape their health. This conception departs from a strictly medical understanding of health. The objective is no longer confined to treating existing diseases, but extends to creating social, economic, political and environmental conditions that are conducive to health. Health promotion is thus grounded in several fundamental principles:

- Population participation;
- The empowerment of individuals and groups;
- Action on the social determinants of health;
- Equity;
- Intersectoral collaboration;
- Collective responsibility;
- Social justice.

Health is therefore conceptualised as a resource that enables individuals and communities to pursue and fulfil their life projects, rather than merely as the absence of disease.

#### **1.1.1. The Turning Point of the Ottawa Charter**

The Ottawa Charter of 1986 constitutes a major landmark in the contemporary history of health promotion. It identifies five principal areas for action:

- building healthy public policies;
- creating supportive environments;
- strengthening community action;
- developing personal skills;

- reorienting health services.

These orientations reflect a fundamental shift in scale: health is no longer regarded as the exclusive responsibility of the healthcare system. Rather, it becomes a concern of society as a whole.

Accordingly, a health promotion policy may simultaneously encompass schools, workplaces, urban planning, the environment, food systems, transport, housing and social services.

### **1.2. Prevention, Health Education and Health Promotion**

The distinction between prevention, health education and health promotion is essential for understanding the different rationales underpinning health action.

#### **Prevention**

Prevention seeks to reduce the likelihood of disease occurring or to limit its consequences. It may be classified as primary, secondary or tertiary prevention.

Primary prevention seeks to prevent the onset of disease. Secondary prevention focuses, in particular, on early detection and screening. Tertiary prevention aims to reduce complications, disability, functional limitations or recurrence.

#### **Health Education**

Health education primarily involves the transmission of knowledge and the promotion of behaviours regarded as conducive to health.

However, it may remain embedded within a top-down logic when professionals are positioned as the holders of legitimate knowledge and populations are regarded merely as passive recipients of information.

#### **Health Promotion**

Health promotion goes beyond the mere modification of individual behaviours. It seeks to act upon the conditions within which behaviours are produced and reproduced.

Individuals do not always freely choose their diet, housing conditions, access to healthcare or working conditions. Individual choices are socially situated and structured by material, institutional and cultural constraints.

Health promotion therefore entails interrogating the social conditions that shape people's capacity to exercise agency.

### **1.3. Empowerment and the Capacity to Act**

Empowerment constitutes a central concept within health promotion. From a sociological perspective, it refers to the process through which

individuals or groups acquire greater capacity to understand their circumstances, participate in decision-making and act collectively upon the conditions that affect their lives.

Empowerment should not, however, be reduced to a process of individual responsabilisation.

Telling an individual that they must “take responsibility for their health” without addressing poverty, environmental conditions, working conditions or inequalities in access to resources amounts to transferring responsibility for a social problem onto the individual. Authentic empowerment therefore presupposes a redistribution of the capacity to act and, more fundamentally, of power itself.

#### **1.4. The Ethical Dimensions of Health Promotion**

Health promotion has a fundamental ethical dimension. Three principles are particularly relevant:

**Autonomy:** Autonomy entails the genuine capacity of individuals to participate in decisions concerning their own health.

##### **Justice**

Health justice requires that resources, opportunities and forms of protection be distributed equitably, taking into account socially produced inequalities in exposure to health risks and access to health-enhancing resources.

##### **Collective Responsibility**

Health cannot be regarded solely as an individual responsibility. Institutions and public authorities also bear responsibility for creating the conditions that enable individuals and communities to achieve and maintain good health.

#### **1.5. Health Promotion and Social Control**

Health promotion possesses an inherently ambivalent dimension. On the one hand, it may foster emancipation through participation, access to information and the strengthening of people's capacity to act.

On the other hand, it may become an instrument of behavioural normalisation. Public health policies can define what constitutes “healthy” behaviour and implicitly categorise certain practices as deviant or undesirable.

A Foucauldian perspective therefore makes it possible to interrogate forms of health-related governmentality through which individuals are encouraged to monitor, discipline and regulate their own conduct.

The sociological question consequently becomes: where does empowerment end and social control begin?

## **Chapter 2 – Actors and Institutional Dynamics**

### **2.1. The Plurality of Health Promotion Actors**

Health promotion is not the responsibility of a single actor. It mobilises a plurality of actors situated within different social and institutional spaces:

- international organisations;
- states;
- local and regional authorities;
- healthcare institutions;
- health professionals;
- non-governmental organisations (NGOs);
- voluntary and civil society organisations;
- community-based organisations;
- traditional and religious leaders;
- educational institutions;
- businesses and employers;
- the media;
- local populations.

This plurality generates a complex configuration of relationships characterised by cooperation, competition, negotiation and, at times, conflict.

### **2.2. International Institutions**

International organisations play a major role in defining contemporary public health norms. The World Health Organization (WHO), in particular, contributes significantly to the production of normative frameworks, the dissemination of recommendations and the formulation of international health policies.

However, the circulation of health norms is never entirely neutral. A norm formulated at the international level must be translated, appropriated and adapted to national and local realities.

Sociology therefore invites us to examine the processes through which health norms are translated, appropriated, negotiated and reinterpreted across different social and institutional contexts.

### **2.3. The State and Public Policy**

The state occupies a central position in the organisation of health policies. It establishes national priorities, mobilises resources, regulates practices and structures healthcare systems. Public action, however, is not merely an administrative process. It also constitutes a space of negotiation among competing social interests and institutional rationalities.

Health policies involve choices concerning:

- priority populations;
- problems deemed urgent;
- available resources;
- intervention mechanisms and programmes;
- performance indicators;
- funding arrangements.

Sociology therefore makes it possible to conceptualise health policies as socially and politically constructed arrangements rather than as purely technical or administrative responses to objectively given problems.

#### 2.4. NGOs and Community-Based Organisations

NGOs frequently play an intermediary role between international institutions, states and populations. They may provide financial resources, technical expertise and organisational capacities.

Community-based organisations, for their part, possess detailed knowledge of local realities. They can facilitate the appropriation of health programmes by local populations and identify needs that may not always be visible within institutional statistics or official administrative categories.

The central challenge is therefore to articulate institutional expertise with local knowledge and situated forms of experience.

#### 2.5. Health Professionals

Health professionals constitute key actors in health promotion. Their role is no longer confined to diagnosing and treating disease. They may also:

- provide information;
- advise;
- support and accompany patients and communities;
- refer and signpost;
- educate;
- mobilise;
- engage in advocacy;
- contribute to policy development.

Nevertheless, their practices remain structured by professional norms, institutional constraints and hierarchical relationships. Health professionals consequently operate at the intersection of several forms of rationality: medical rationality, administrative rationality, economic rationality and relational rationality.

#### 2.6. Populations as Health Actors

A genuinely participatory approach to health promotion regards populations not merely as beneficiaries of health interventions, but as collective subjects capable of producing knowledge and participating in decision-making processes.

Lay and experiential knowledge may provide essential insights into:

- representations of illness and health;
- everyday practices;
- economic constraints;
- therapeutic itineraries and pathways to care;
- adaptive strategies;

- perceptions and interpretations of health policies.

Recognising such forms of knowledge constitutes an important condition for the democratisation of health action.

#### 2.7. Intersectoral Action

Health is produced through the interaction of multiple sectors of society. A health promotion policy must therefore establish links with:

- education;
- agriculture;
- the environment;
- urban planning;
- housing;
- transport;
- employment;
- social affairs.

This approach makes it possible to conceptualise health as the outcome of an intersectoral configuration of determinants rather than as the product of the healthcare system alone.

### Chapter 3 – Social, Economic and Environmental Determinants of Health

#### 3.1. Health as a Social Fact

Health is not distributed evenly across populations. Individuals have access to different resources depending on their social position, level of education, income, occupation, place of residence and membership of particular social networks. Sociology therefore seeks to understand why certain social groups are disproportionately exposed to particular health risks.

#### 3.2. Forms of Capital and Health Practices

Bourdieu's theory (1979) provides a framework for analysing how economic, cultural and social resources shape practices. Economic capital, in particular, conditions individuals' capacity to access certain goods and services. Cultural capital influences skills, knowledge and relationships with institutions. Social capital refers to resources accessible through social relationships and networks.

These different forms of capital may influence:

- dietary practices;
- healthcare utilisation;
- access to information;
- preventive behaviours;
- the capacity to negotiate with institutions.

Health behaviours should therefore not be analysed independently of individuals' social positions.

### 3.3. Economic Conditions

Poverty constitutes a major determinant of health. Low income may constrain:

- access to a diverse and nutritious diet;
- access to adequate housing;
- transport opportunities;
- access to healthcare;
- the ability to comply with certain medical prescriptions;
- the possibility of allocating time to preventive activities.

Economic inequalities may therefore be translated into health inequalities.

### 3.4. Working Conditions

Work also constitutes a major determinant of health. Exposure to occupational hazards, precarious employment, demanding working hours, stress, limited occupational autonomy and economic insecurity may have significant consequences for health.

The sociology of work consequently provides a framework for analysing the relationships between the organisation of work, hierarchical relations and health outcomes.

### 3.5. The Physical and Urban Environment

The environment directly influences people's opportunities to live in good health. Air quality, access to safe drinking water, sanitation, waste management, housing, green spaces and transport infrastructure all constitute important environmental determinants of health.

In cities characterised by pronounced spatial inequalities, socioeconomically disadvantaged populations may be disproportionately exposed to environmental hazards. Health thus becomes not only a public health issue, but also a question of spatial and environmental justice.

### 3.6. Social Inequalities in Health

Social inequalities in health refer to systematic differences in health status between social groups. They are not merely the outcome of individual differences; rather, they are associated with structural social mechanisms.

These mechanisms may include:

- the unequal distribution of resources;
- differences in exposure to risks;
- differences in vulnerability;
- differences in the capacity to mobilise resources;
- social trajectories;
- discrimination;
- intergenerational effects.

### 3.7. The Social Reproduction of Health Inequalities

The theory of social reproduction helps explain how certain disadvantages may persist over time. Living conditions during childhood may influence subsequent educational, occupational and health trajectories.

Habitus contributes to structuring durable ways of perceiving, thinking and acting. Health may therefore be understood as the outcome of a socially situated biographical trajectory.

### 3.8. Gender, Age and Vulnerabilities

Gender relations also shape experiences of health and illness. Women and men may be exposed to different risks as a result of the social division of labour, gender norms, family responsibilities and power relations.

Age likewise constitutes an important dimension. Children, adolescents and older people possess specific resources and encounter distinctive constraints. Health promotion policies must therefore take into account the diversity and heterogeneity of social experiences.

### 3.9. Public Policies and Inequalities

Public policies may contribute to reducing inequalities, but they may also reproduce them when they fail to take account of social differences between populations.

A universal policy does not necessarily produce universal effects. The principle of equity precisely entails taking differences in social circumstances into account in order to create fairer conditions and reduce avoidable inequalities.

## Chapter 4 – Methodologies and Intervention Strategies in Health Promotion

### 4.1. Community Diagnosis

Community diagnosis constitutes a fundamental stage in the development of health promotion interventions. It involves identifying, together with local populations:

- health problems;
- needs;
- available resources;
- relevant actors;
- constraints;
- representations and perceptions;
- local priorities.

Unlike an exclusively top-down expert assessment, community diagnosis is grounded in meaningful population participation and the recognition of locally situated knowledge.

#### 4.2. Participatory Research

Participatory research involves populations at different stages of the knowledge-production process. It may draw upon:

- interviews;
- focus groups and group discussions;
- observation;
- social mapping;
- life histories;
- participatory photography;
- collective workshops.

Such approaches make it possible to produce contextualised knowledge of health problems while incorporating the experiential knowledge of the populations concerned.

#### 4.3. Action Research

Action research establishes a close relationship between knowledge production and social transformation. The researcher does not merely observe a problem; rather, they work alongside the actors concerned to identify the problem, formulate an appropriate response, implement it and evaluate its effects.

This approach requires a high degree of researcher reflexivity, particularly with regard to the researcher's position, power relations and involvement in the field of intervention.

#### 4.4. Health Communication

Communication constitutes an important instrument of health promotion. However, communication does not simply consist of transmitting a message. Its effectiveness depends upon:

- the language employed;
- social representations;
- levels of trust in institutions;
- previous experiences;
- cultural norms;
- social relations;
- communication channels.

Effective health communication must therefore be socially and culturally contextualised. It must take into account not only what is communicated, but also the social conditions under which messages are received, interpreted and potentially translated into practice.

#### 4.5. Advocacy

Advocacy seeks to influence public decision-making in order to secure recognition of a particular issue or bring about institutional change. It may concern:

- resources;
- infrastructure;
- public policies;
- regulatory norms;
- rights;

- the environment;
- access to healthcare.

Advocacy can therefore be understood as a form of political action oriented towards the promotion and protection of health.

#### 4.6. Community Empowerment

Community empowerment involves the development of collective capacities for action. It may be pursued through:

- the establishment of local committees;
- capacity-building and training of stakeholders;
- participation in decision-making;
- networking;
- access to information;
- the development of community-led initiatives.

The objective is not merely to involve populations in a programme that has already been designed elsewhere, but to enable them to participate in defining the problem itself and in determining appropriate solutions.

#### 4.7. Implementation of Health Promotion Interventions

A health promotion intervention should be developed on the basis of a prior and context-sensitive diagnosis. It may proceed through several stages:

Diagnosis → prioritisation → planning → stakeholder mobilisation → implementation → monitoring → evaluation → readjustment.

Each stage should incorporate the social, cultural, political and institutional dimensions of the intervention context.

#### 4.8. Evaluation

Evaluation makes it possible to assess the effects and consequences of an intervention. It may examine:

- effectiveness;
- efficiency;
- relevance;
- equity;
- acceptability;
- participation;
- sustainability.

A sociological evaluation should also seek to identify the unintended effects of a programme and examine transformations in relationships between stakeholders, institutional configurations and forms of power. It should therefore go beyond the measurement of predefined outcomes to investigate how interventions are appropriated, negotiated and potentially reconfigured by the actors involved.

## Chapter 5 – Case Study: Breastfeeding as an Object of Health Promotion

Breastfeeding constitutes a particularly valuable case through which to analyse the relationships between health norms, cultural practices and social constraints. Health policies may present breastfeeding as a practice beneficial to the health of both the child and the mother. However, the implementation of this recommendation depends upon multiple and interrelated factors. It is therefore necessary to examine, in particular:

- cultural representations of breast milk and breastfeeding;
- family norms;
- the influence of grandmothers;
- professional advice and guidance;
- economic conditions;
- women's working conditions;
- maternity leave policies;
- commercial practices;
- gender relations.

Breastfeeding should therefore not be understood merely as an individual behaviour. Rather, it constitutes a socially situated practice, shaped by norms, resources and constraints within the social environment.

A breastfeeding promotion policy that merely tells women what they ought to do risks producing maternal guilt and individualising responsibility. A sociological approach would instead seek to identify the social conditions that genuinely enable women to implement recommended practices. This case study thus illustrates a fundamental distinction between individual responsabilisation and the creation of social conditions conducive to agency and action.

## CONCLUSION

Health promotion has become a major field within both public health and the sociology of health. It reflects a profound shift in the conceptualisation of health: health is no longer understood solely as the outcome of biomedical intervention, but as a social construction shaped by the economic, political, cultural, environmental and relational conditions within which individuals and groups live.

A sociological approach demonstrates that health behaviours cannot be separated from the social structures that make particular forms of action possible or impossible. Individuals possess unequal capacities for action according to their resources, social position, cultural, economic and relational capital, and the environments in which they live.

Health promotion should therefore be conceptualised as a sociopolitical process aimed at transforming living conditions and strengthening people's capacity to act. It requires meaningful population participation, recognition of lay knowledge,

articulation between scientific expertise and social experience, and collaboration across the different sectors of society.

However, this approach remains marked by a fundamental tension. Health promotion may constitute a powerful instrument of emancipation when it enables populations to participate in decisions affecting their health. It may also become an instrument of normalisation when it transforms individuals into the sole bearers of responsibility for their health status while obscuring the structural determinants that shape their circumstances.

The scientific and political challenge is therefore to construct a form of health promotion that does not merely ask populations to change their behaviours, but also contributes to transforming the social conditions within which such behaviours acquire meaning and become possible.\*

Health promotion thus emerges as a genuine instrument of social transformation, grounded in equity, participation, social justice, empowerment and health democracy.

## Pedagogical Guidance for Tutorials

Tutorial sessions are intended to transform the theoretical knowledge acquired through lectures into practical capacities for sociological analysis. They pursue four principal objectives:

- ✓ to assess students' appropriation of key concepts;
- ✓ to develop critical analytical capacities;
- ✓ to connect theoretical concepts with concrete situations;
- ✓ to develop the competencies required to design health promotion interventions.

## I. Comprehension Exercises

### Exercise 1 – Defining Fundamental Concepts

**Question:** What is the fundamental difference between prevention, health education and health promotion?

#### • Key points for the Answer

Prevention primarily seeks to reduce risks or prevent the onset and progression of diseases.

Health education primarily aims to transmit knowledge and encourage changes in specific health-related behaviours.

Health promotion has a broader scope: it seeks to strengthen the capacity of populations to act and to transform the social, economic, political and environmental conditions that shape health.

## Exercise 2 – The Ottawa Charter

**Question:** Why does the Ottawa Charter of 1986 constitute a turning point in the history of public health?

- **Key points for the answer**

It marks a paradigm shift by placing at the centre of health action:

- participation;
- empowerment;
- community action;
- healthy public policies;
- supportive environments;
- the reorientation of health services.

It therefore extends responsibility for health beyond the healthcare system alone.

## II. Sociological Analysis Exercises

### Exercise 3 – Health and Power Relations

#### Question

How does conceptualising health as a field of power transform the analysis of health policies?

- **Key points for the answer**

Health constitutes a social field in which different actors possess unequal resources and capacities to exert influence.

Professionals, institutions, public authorities, NGOs and populations do not necessarily possess the same capacity to define problems, impose norms or influence decision-making.

Sociological analysis therefore makes it possible to examine the power relations that structure the production, implementation and interpretation of health policies.

### Exercise 4 – Health and Social Reproduction

#### Question

Show how social conditions may contribute to the reproduction of health inequalities.

- **Key points for the answer**

Health inequalities may be reproduced through the unequal distribution of economic, cultural and social capital.

Individuals belonging to more advantaged social groups generally have greater access to resources that enable them to obtain information, services, infrastructure and healthcare.

Disadvantages may also accumulate over the life course and be transmitted indirectly from one generation to the next.

## III. Application Exercises

### Exercise 5 – Community-Based Case Study

#### Situation

In a disadvantaged urban neighbourhood, residents are heavily exposed to air pollution, waste and a lack of green spaces.

**Question:** Propose a health promotion intervention based on the principles of the Ottawa Charter.

#### Expected answer

The intervention could include:

- a participatory community diagnosis;
- identification of the main sources of pollution;
- mobilisation of local associations;
- collaboration among health, environmental, urban planning and local government services;
- establishment of a citizens' committee;
- advocacy directed towards public authorities;
- environmental health education;
- development of health-supportive spaces and environments;
- participatory monitoring;
- evaluation of the programme's effects.

This approach makes it possible to articulate community participation, empowerment, intersectoral action and environmental justice.

## IV. Comparative Exercise

### Exercise 6 – International NGO and Community-Based Actor

#### Question

Compare the intervention rationales of an international NGO and a local community-based actor.

- **Key points for the answer**

An international NGO may possess technical expertise, financial resources and the capacity to mobilise international norms and standards.

A community-based actor, by contrast, possesses contextualised knowledge of local realities, practices and representations.

A relevant intervention should avoid opposing these two forms of knowledge and instead seek to establish a process of co-production of knowledge and intervention strategies.

## V. Critical Discussion Exercise

### Exercise 7 – Emancipation or Social Control?

**Topic:** "Is health promotion an instrument of emancipation or an instrument of social control?"

### Points for Reflection

Students should demonstrate that health promotion possesses an inherently ambivalent dimension. It may be emancipatory when it:

- strengthens autonomy;
- promotes participation;
- recognises lay knowledge;
- develops collective capacities;
- advances health democracy.

It may become an instrument of social control when it:

- imposes behavioural norms;
- individualises and moralises responsibility;
- moralises everyday practices;
- monitors and regulates conduct;
- transforms structural problems into individual responsibilities.

The expected answer should therefore move beyond a binary opposition and demonstrate that health promotion constitutes a field of tension between power, knowledge, autonomy and social control.

### VI. Synthesis Exercise

#### Exercise 8 – Sociological Essay

**Topic:** Are health inequalities primarily social inequalities?

#### Suggested Structure

##### I. Health is Socially Distributed

- social position;
- income;
- educational attainment;
- occupation;
- housing;
- environment.

##### II. Forms of Capital Structure Health Practices

- economic capital;
- cultural capital;
- social capital;
- habitus;
- differentiated access to resources.

##### III. The Limitations of an Exclusively Individualistic Interpretation

- individual responsibility;
- structural constraints;
- social reproduction;
- public policy;
- social justice.

#### Expected Conclusion

Students should demonstrate that individual behaviours cannot be separated from the social structures that shape, constrain and enable them.

### VII. Personal Reflection Exercise

#### Topic

Drawing upon a personal or professional experience, or an observation from the field, identify a situation in which a health promotion intervention contributed to transforming a collective practice. Analyse this situation using the following concepts:

- empowerment;
- participation;
- social justice;
- lay knowledge;
- institutional intervention;
- social change.

#### Expected Structure

##### Students Should Present:

1. the context;
2. the health problem;
3. the actors involved;
4. the resources mobilised;
5. the strategies employed;
6. the transformations observed;
7. the forms of resistance encountered;
8. the limitations of the intervention;
9. the sociological lessons derived from the experience.

#### Specific Learning Objectives and Competencies to Be Acquired

##### Specific Objective 1: Define Health Promotion

By the end of the course, students should be able to:

- define health promotion;
- distinguish between prevention, health education and health promotion;
- explain the principles of the Ottawa Charter;
- analyse the concept of empowerment.

##### Specific Objective 2: Identify Key Actors

Students should be able to:

- identify the actors involved in health promotion;
- analyse their respective roles;
- understand their interests;
- examine their relationships of cooperation and power;
- analyse community dynamics.

##### Specific Objective 3: Analyse the Determinants of Health

Students should be able to:

- identify social determinants of health;
- analyse economic determinants;
- integrate environmental dimensions;
- explain the production of social inequalities in health;
- analyse mechanisms of social reproduction.

## Specific Objective 4: Master Intervention Methodologies

Students should be able to:

- conduct a community diagnosis;
- design a participatory research study;
- employ an action-research approach;
- develop a health promotion strategy;
- construct appropriate evaluation indicators;
- analyse the effects of an intervention

## Teaching methods

Teaching is based on a pedagogical approach that combines lecturer-led instruction, critical discussion and experiential learning. Lectures provide students with the key concepts, theoretical frameworks and research findings underpinning the course. Digital resources, conceptual diagrams, case studies and audiovisual materials are used to facilitate the acquisition and understanding of complex concepts.

Teaching also places particular emphasis on a dialogical approach. Students are encouraged to confront theoretical concepts with their field observations and lived social experiences. Tutorials provide a progressive transition:

From understanding → to analysis → to application → to critical evaluation → to the development of independent thinking.

At the end of the course, the written course materials may be made available to students as a reference document.

## Assessment Methods

Assessment is based on two complementary components.

## Formative Assessment

Tutorials, exercises, case studies and practical assignments account for 40% of the final mark in the first examination session. This component assesses:

- mastery of key concepts;
- analytical abilities;
- the capacity to mobilise theoretical frameworks;
- the ability to address and resolve practical problems.

## Summative Assessment

The final examination accounts for 60% of the mark in the first examination session and contributes to the assessment in both examination sessions. The final assessment focuses in particular on:

- mastery of the theoretical foundations;
- understanding of key concepts;
- sociological analytical capacity;

- the application of knowledge to concrete situations;
- the construction of a coherent scientific argument.

Course validation is subject to the academic regulations in force, including attainment of the required pass mark.

## Synoptic Architecture of the Pedagogical Progression

The pedagogical progression follows a logic that moves from concepts to action, and from action to evaluation:

### Introduction

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### Sequence 1: Understanding Health Promotion

Chapter 1 – Understanding the Concept

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### Sequence 2: Conceptual Foundations and the Ottawa Charter

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### Sequence 3: Prevention, Health Education and Health Promotion

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### Sequence 4: Empowerment, Autonomy and Participation

Chapter 2 – Identifying Actors and Social Relations

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### Sequence 5: Actors and Institutions

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### Sequence 6: Health Professionals, Populations and Lay Knowledge

Chapter 3 – Understanding Determinants and Inequalities

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### Sequence 7: Social and Economic Determinants

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### Sequence 8: Environment, Urbanisation and Health

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### Sequence 9: Social Inequalities in Health and Social Reproduction

Chapter 4 – Acting and Evaluating

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### Sequence 10: Participatory Methodologies and Action Research

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### Sequence 11: Intervention Strategies, Communication and Advocacy

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### Sequence 12: Case Study and Evaluation

Conclusion

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### Sequence 13: Overall Synthesis and Preparation for Assessment

## Final Pedagogical Synthesis

The overall logic of the course can be summarised through the following framework:



Health promotion, as conceptualised here, is therefore reduced neither to disease prevention nor to the education of individuals. Rather, it constitutes a collective process of transforming the social conditions under which health is produced, bringing together scientific knowledge, lay knowledge, institutions, communities, public policies and relations of power.

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