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Toward International Collaboration on Credentialing in Health Promotion and Health Education: The Galway Consensus Conference

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The interest in competencies, standards, and quality assurance in the professional preparation of public health professionals whose work involves health promotion and health education dates back several decades. In Australia, Europe, and North America, where the interest in credentialing has gained momentum, there have been rapidly evolving efforts to codify competencies and standards of practice as well as the processes by which quality and accountability can be ensured in academic professional preparation programs. The Galway Consensus Conference was conceived as a first step in an effort to explore the development of an international consensus regarding the core competencies of health education specialists and professionals in health promotion and the commonalities and differences in establishing uniform standards for the accreditation of academic professional preparation programs around the world. This article describes the purposes, objectives, and process of the Galway Consensus Conference and the background to the meeting that was convened.

Keywords: *accreditation; certification; consensus conference; credentialing; health education; health promotion; international health; professional preparation; public health workforce*

Alarm over the increasing prevalence of infectious and chronic diseases, as well as the deteriorating public health infrastructure in the United States and in other countries, has catalyzed renewed interest in the professional preparation and training of the public health workforce. In the United States, two major reports from the prestigious Institute of Medicine have sounded wake-up calls for sweeping changes needed in the education

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and training of public health workers to protect the public's health. Among other recommendations, the Institute of Medicine's Committee on Assuring the Health of the Public in the 21st Century (2003) called for a broad-based national dialogue to explore perspectives on workforce credentialing. A complementary Institute of Medicine report (Gebbie, Rosenstock, & Hernandez, 2003) called for a new approach to educating public health professionals in the 21st century, noting that significant new areas of competency and expertise—including communication, cultural competence, community-based participatory research, global health, policy and law, and ethics—are now required of the public health workforce to meet contemporary challenges.

On a broader, international scale, the report of the World Health Organization's Commission on Social Determinants of Health (2008) pointed to what Michael Marmot, the chair of the commission, has called "a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics" (p. 1) that has contributed to global health inequities. One of the commission's recommendations calls for providing training on the social determinants of health to policy actors, stakeholders, and practitioners. All of these reports speak to the importance of the need to improve public health capacity through better systems of credentialing.

Significant strides have been made in recent decades, particularly in Australia, Europe, and North America, to promote quality assurance in the training and credentialing of health promotion and health education professionals. Despite the distinct differences in professional preparation and credentialing of such professionals, these transcontinental quality assurance efforts share common goals: (a) to protect the public by establishing and ensuring a minimum acceptable standard of quality and performance for professionals working in population health, (b) to improve or strengthen institutions and programs of professional preparation through systems of external peer review and increased public accountability, and (c) to promote continued professional development of the workforce in an effort to strengthen public health capacity.

This article describes the purposes, objectives, and process of the Galway Consensus Conference and the background to the meeting that was convened in June

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We also wish to thank everybody who took the time to comment on the draft Galway Consensus Statement and shared their views with us.

We are pleased that for the first time, the Society for Public Health Education and the International Union for Health Promotion and Education are collaborating to produce concurrent and complementary issues of their journals, *Health Education & Behavior* and *Global Health Promotion*, respectively. We wish to acknowledge the editors and editorial staff of both journals in making these landmark publications possible. We also wish to acknowledge SAGE Publications, Inc., for its efforts in publishing these concurrent publications just 12 months following the Galway Conference and for arranging open access to all the articles online to encourage the broadest dissemination possible. To read the entire collection of articles, go to <http://online.sagepub.com> and search for "Galway Consensus."

2008. We begin by describing a brief history by region of the international situation in credentialing for health promotion and health education to provide the current context in which the idea for the Galway Consensus Conference was conceived. Credentialing in this context refers to several processes put in place to ensure that persons who deliver a given service have obtained a minimum level of competency, including accreditation of institutions as well as licensure, certification, or registration of individuals.

HISTORY OF INTERNATIONAL EFFORTS IN CREDENTIALING

Efforts to establish credentialing processes and systems for health promotion and health education are relatively recent compared to those of other health professions such as nursing and medicine, which date back to the 1700s (Cleary, 1995; Creswell, 1981; Green, 1991). In the United States, where such efforts have evolved since the early 1970s, the credentialing of health educators has significantly strengthened the health education profession during the past quarter century (Allegrante, Auld, Butterfoss, & Livingood, 2001; Livingood & Auld, 2001). Despite debates over the advantages and disadvantages of adopting the cultural authority of the established professions through formalized credentialing (e.g., see Bartlett & Windsor, 1985; Cortese, 1990; Livingood et al., 1993; Ovrebo & Williamson, 1990), health education in the United States has emerged as the first population-based health profession with a national system of individual certification and continuing professional development (Livingood & Auld, 2001). This system is administered by the National Commission for Health Education Credentialing, Inc. (National Commission on Health Education Credentialing, 2008a) and is grounded in extensive research that has been conducted to identify competencies for professional practice in health education.

The first Role Delineation Project to define the role and competencies of the entry-level health educator was conducted from 1979 to 1981 (Henderson & McIntosh, 1981; Henderson, McIntosh, & Carlyon, 1980; Henderson, McIntosh, & Schaller, 1981; Henderson, Wolle, Cortese, & McIntosh, 1981). More recently, the National Health Educator Competencies Update Project was undertaken from 1998 to 2004 to reverify the role of entry-level health educators and further define and verify the role of graduate (American Association for Health Education, National Commission for Health Education Credentialing, Inc., and Society for Public Health Education, 1999) and advanced-practice health educators (Airhihenbuwa et al., 2005; Gilmore, Olsen, & Taub, 2004; Gilmore, Olsen, Taub, & Connell, 2005). During that time, a parallel effort was undertaken to identify the continuing-education needs of the currently employed public health workforce, including public health educators (Allegrante, Moon, Auld, & Gebbie, 2001; Gielen, McDonald, & Auld, 1998), and better understand the broader emerging public health workforce development needs (Lichtveld et al., 2001).

The Competencies Update Project eventually identified 35 competencies and 163 subcompetencies organized under seven major areas of responsibility. These competencies have been codified and serve as the basis for professional preparation, credentialing, and continuing professional development (Gilmore, Olsen, & Taub, 2007). The U.S. system of individual certification involves both a comprehensive competency-based examination and rigorous requirements for continuing education that provide public accountability for the qualifications of individual health educators who achieve the designation of Certified Health Education Specialist (CHES). The value of such a system was reinforced in 1998 with the recognition of health educator as a distinct professional occupation in the Standard Occupational Classification Index of the U.S.

Department of Labor (U.S. Department of Labor, Bureau of Labor Statistics, 2008) and its reverification in 2009 (Office of Management and Budget, 2009). As of June 2008, the Certified Health Education Specialist examination, which is administered by the National Commission for Health Education Credentialing, was granted accreditation by the National Commission for Certifying Agencies. This represents a "gold standard" endorsement and signifies that the National Commission for Health Education Credentialing is in compliance with stringent testing and measurement standards among national health testing organizations (National Commission on Health Education Credentialing, 2008b). In the summer of 2008, the National Board of Public Health Examiners also initiated a new voluntary examination for public health professionals, including health educators, who have graduated from a school or program of public health that has been accredited by the Council on Education for Public Health (Calhoun, Ramiah, McGean, & Shortell, 2008).

Recent efforts to improve quality assurance in the United States have sought to couple this established individual-level credentialing with a more unified system of accreditation for academic professional preparation programs. Interest in the issues of accrediting institutions that prepare professional health educators and of certifying individuals dates back to the 1970s (Green, 1976). Over subsequent decades, the American scene has adopted a patchwork of mechanisms that have been designed to ensure quality in academic preparation at an institutional level. Although academic preparation in health education is one of the criteria for individual certification, graduation from an accredited program has not yet been linked to eligibility for the Certified Health Education Specialist examination. A combination of program approval through the Society for Public Health Education and the American Association for Health Education, along with parallel accreditation mechanisms administered by the Council on Education for Public Health, the National Council on Accreditation in Teacher Education, and the Teacher Education Accreditation Council, has helped raise standards of quality assurance in academic professional preparation programs for public health education specialists and health teachers in the school setting. However, universal implementation of a unified accreditation system that was recommended by the first National Task Force on Accreditation in Health Education in 2004 (Allegrante et al., 2004) has yet to be achieved.

Similar credentialing efforts are now being pursued in Canada where there has been sustained interest in health promotion since publication in 1975 of the LaLonde Report on the health of Canadians (LaLonde, 1975). Since then, Canadians have debated issues of education and training in health promotion (O'Neill & Hills, 2000a) and who will have jurisdiction over setting standards for professional preparation and practice (Green, 1995). The first pan-Canadian discussions regarding the identification of competencies for health promotion practitioners occurred in 2000 at a symposium of the Canadian Association of Teachers of Community Health (O'Neill & Hills, 2000b). Later, in 2006, Health Promotion Ontario began the process of drafting competencies for health promotion specialists in Canada (Hyndman, 2007). A report on core competencies for public health in Canada was subsequently published by the Public Health Agency of Canada (2007), and it outlined 36 core competencies across seven major categories, including the essential knowledge, skills, and attitudes necessary for the practice of public health, including health promotion. Moreover, these efforts to codify competencies are occurring in the context of discussions regarding the feasibility of developing both accreditation standards and an accreditation process for public health in Canada (Beaumont, Drew, & Contandriopoulos, 2007). In contrast to U.S. efforts,

the development of Canadian health promotion competencies at this stage is not seen as a step toward mandatory accreditation of health promotion specialists but rather as a process that will inform and strengthen health promotion practice in an inclusive manner.

In Australia and New Zealand, efforts to identify competencies for health promotion professionals date back to the early 1990s and have continued into the 2000s (Howat et al., 2000). Initial efforts were undertaken by the Australian Health Promotion Association in conjunction with Curtin University, the Australian Heart Foundation, and the Western Australia Health Department (Shilton, Howat, James, & Lower, 2002, 2003). The competencies were subsequently revised by the Australian Health Promotion Association and the National Health Promotion Workforce Development Task Group, a committee of the National Public Health Partnership Group. They were further updated in 2005 by the Australian Health Promotion Association, the Public Health Association of Australia Health Promotion Special Interest Group, and the International Union for Health Promotion and Education (IUHPE) South Western Pacific Regional Committee (Shilton et al., 2008). Similar efforts to develop competencies for health promotion have been launched and are unfolding in nearby New Zealand (McCracken & Rance, 2000).

During the past decade, member states of the European Union and Council of Europe also began to codify core competencies and standards for accreditation of the professional preparation of public health and health promotion professionals (García Sánchez & March Cerdá, 1999). Following the Bologna Declaration (European Higher Education Area, 1999), the European Association for Quality Assurance in Higher Education in Europe issued a statement of standards and guidelines and for quality assurance in the higher education area, which provides a context for quality assurance in the professional preparation of health promotion professionals within the framework for the European Masters in Health Promotion (Meresman et al., 2006). In addition, the Association of Schools of Public Health in the European Region and the European Accreditation Agency for Public Health Education are developing standards and quality criteria for the education of public health professionals, including those working in health promotion and disease prevention (Association of Schools of Public Health in the European Region, 2007). The IUHPE European Regional Committee formed a subcommittee in 2005 to make recommendations for the development of a European Professional Accreditation System in Health Promotion based on standards and competencies on which there was agreement. Following a scoping study (Santa-Maria Morales & Barry, 2007) on training and accreditation in health promotion across the European region, a pilot implementation of a pan-European framework for accreditation in a number of member states was launched.

Interest in competencies, standards, and quality assurance and accountability in the professional preparation of public health professionals whose emphasis is on health promotion and health education has increased in other countries and regions of the globe as well. Spain (Irigoin & Vargas, 2002), Japan (Sakagami, 2004), and Israel (Melville, Howat, Shilton, & Weinstein, 2006) have all sought to develop systems of credentialing in an effort to join the broader European, North American, and Southwest Pacific region in professionalizing health promotion and health education. Beyond these, the People's Republic of China, India, and Taiwan have engaged in nascent efforts to improve health promotion practice, leaving Africa the only remaining major region of the world where the movement has yet to materialize.

This brief review of credentialing efforts in health promotion and health education suggests that ensuring the competency of public health professionals has emerged as an

important priority in a majority of those countries with advanced economies in several regions of the world (Baker et al., 2005). Thus, the time has arrived to explore the development of international consensus regarding the core competencies of health educators and professionals in health promotion as well as the commonalities and differences in establishing uniform standards for the accreditation of professional preparation programs globally.

PURPOSE, OBJECTIVES, AND PROCESS OF THE CONFERENCE

Building on symposia presented at the 18th IUHPE World Conference on Health Promotion and Education in Melbourne, Australia, in 2004, and two symposia that were presented at the 19th World Conference on Health Promotion and Education in Vancouver, Canada, in 2007, the Galway Consensus Conference sought to convene an international group of leaders in health promotion and health education to explore greater international collaboration on the development of workforce capacity. More specifically, the conference was a first effort to identify and codify common areas of agreement around competencies, standards, and approaches to quality assurance in professional preparation.

Purpose

The purpose of the Galway Consensus Conference was to promote global exchange and understanding concerning core competencies and accreditation in the professional preparation of health promotion and health education specialists. The conference was designed to explore the development and implementation of credentialing systems and consider the issues and optimal mechanisms for developing individual and institutional-based credentialing across countries and continents. Toward this end, the conference convened a working group of scholars and leaders, most of whom came from Europe and North America, along with other stakeholders and interested parties, that have been prominent in public health workforce development and the competency-based and accreditation movements in public health and health promotion.

Objectives

The objectives of the Galway Consensus Conference were to:

1. review the literature and exchange experiences and lessons learned in identifying competencies, developing standards, and establishing accreditation systems for health promotion and health education specialists and
2. generate a consensus conference statement that outlines the position of participating experts on core competency, standards, and accreditation mechanisms in health promotion and health education.

Process

To plan the conference, a conference secretariat was formed and began meeting via monthly telephone conference calls in the autumn of 2007. The secretariat comprised the designated cochairs of the conference (Allegrante and Barry), the executive

directors of IUHPE and the Society for Public Health Education (Lamarre and Auld, respectively), and an at-large member (Taub). The secretariat was responsible for developing the program for the conference, managing logistics, and commissioning writing groups to prepare draft review papers that would form the basis of the background readings for the conference and subsequent manuscripts.

The conference was convened and hosted on the campus of the National University of Ireland, Galway, from June 16 to 18, 2008. Of the approximately 35 participants who were invited from each region of the globe (including Africa, Asia-Pacific, Europe, Latin America, and North America), 26 individuals accepted the invitation and attended the conference. Although the conference sought to engage the participation of representatives from throughout every region of the world, those from the African, Asian Pacific, and Latin American regions either could not be represented or were underrepresented due to various scheduling or travel constraints. Regrettably, this also meant that some of the poorer regions of the world—where health promotion and health education efforts perhaps have the most to contribute—were not represented. Those who did attend and participate were largely from Europe and North America and came from institutions of higher education, key governmental entities, nongovernmental organizations, and professional societies at the national and global levels (see the appendix).

The papers that the conference secretariat commissioned to inform the deliberations represented state-of-the-art reviews of the literature related to credentialing in health promotion and health education, including competency-based professional preparation and assessment, standards, and approaches to quality assurance. Each of the papers was presented by its principal author at the conference and discussed both in plenary sessions and in small groups. The papers also informed the writing of a draft consensus statement that was generated by the consensus statement-writing group. The preliminary draft of the consensus statement was presented and discussed in a plenary session at the end of the second day of the conference. The draft consensus statement underwent two subsequent revisions in response to discussion and comment before a final draft was ratified by the participants on the closing day of the conference.

Immediately following the conference, the final draft consensus statement that was ratified by the conference participants was posted online and circulated among professionals, employers, and other interested groups for comment over a 6-month period from July 1, 2008, to January 31, 2009. A press release was issued about the conference and invited comments and feedback about the statement. Correspondence was also sent to key informants throughout the world who were not represented at the conference, requesting comment on the draft consensus statement. Electronic public comment forums were created at the Web sites of the Society for Public Health Education and, subsequently, IUHPE, where comments, suggestions, and recommendations could be posted. Feedback on the draft consensus statement was received from more than 80 individuals and organizations around the globe. All comments, suggestions, and recommendations were reviewed by the consensus statement-writing group in February 2009.

Response to the statement from both the survey and letters was overwhelmingly positive and provided further encouragement in refining and disseminating such an international consensus statement. However, some Canadian respondents to the online survey were less satisfied and felt critical references to the competencies were not acknowledged. Others requested more information on the process of developing the domains and/or asked for them to be further clarified or expanded. In a content analysis

of the recommendations, the following themes emerged where the current descriptions of the domains could be strengthened:

1. *Communication*—Statement needs more emphasis on cultural proficiency, cultural competency, and negotiation skills.
2. *Empowerment*—Statement needs more direct, uncompromising emphasis on the imbalance of power in our health systems, which leads to the injustices we all aspire to resolve.
3. *Leadership, Budgeting, Management and Infrastructure*—Statement lacks sufficient emphasis on the need for health promotion specialists to demonstrate more knowledge and skills related to leadership and administration.
4. *Partnerships and Intersectoral Collaboration*—Statement needs more emphasis on the role of health promotion specialists in building alliances and partnerships to encourage collaboration between health and other nonhealth sectors.
5. *Planning, Implementation, and Evaluation*—Statement needs to reference the ecological model; more emphasis on evaluation and measurement of impact and outcomes is needed.

Although the consensus statement-writing group felt that not all comments and suggested edits could be incorporated without further dialogue, the draft statement was revised in response to both public and editorial reviewer comment and subsequently published (see Allegrante et al., 2009; as well as Barry, Allegrante, Lamarre, Auld, & Taub, 2009). Further, the writing group hopes to help organize a series of sessions related to global competencies and quality assurance at the 20th World Conference on Health Promotion and Education in Geneva, Switzerland, in 2010, in an ongoing effort to promote continued dialogue on this topic.

CONCLUSION

With the rapidly increasing globalization of threats to human health, international health issues are likely to have increasing impact on the work of health promotion and health education specialists whether they are in Bangkok, Cape Town, or New York. Global health problems—infectious diseases such as HIV/AIDS and malaria, injuries, and the increase in chronic diseases such as cardiovascular disease and diabetes—will require health promotion professionals to demonstrate the competency and skills to meet such challenges using the best practice-based evidence and newest technologies available. Opening the dialogue on the conceptual foundations for transcontinental approaches to credentialing and quality assurance systems holds the promise of ensuring that they are in a position to do so. Such systems are already maturing in North America, the Southwest Pacific, and some countries across Europe. However, much more effort in setting standards, identifying competencies, and establishing mechanisms of quality assurance in professional preparation, regrettably, is only in its infancy in other regions where there are precious few available resources to build workforce capacity.

The Galway Consensus Conference is a first step in reaching international accord on the competencies and quality assurance mechanisms necessary for the professional preparation of health promotion and health education specialists in an effort to improve workforce capacity and advance the global health agenda through health promotion. A wider consultation process will be necessary if we are to continue to build international consensus with regard to core competencies for health promotion. The outcomes of the

Galway Consensus Conference thus promise to have important implications for strengthening professional preparation, training, and continuing education of those who practice health promotion in many parts of the world. Moreover, the Galway process and outcome can inform the efforts of other public health disciplines that are now also striving to meet the global public health challenges of the 21st century.

APPENDIX

Toward International Collaboration on Credentialing in Health Promotion and Health Education: The Galway Consensus Conference

Meeting Cochairs: Prof. John P. Allegrante, Columbia University, New York, USA (Past President of the Society for Public Health Education), and Prof. Margaret M. Barry, National University of Ireland, Galway (Global Vice-President for Capacity-Building, Education & Training of the International Union for Health Promotion and Education).

Meeting Participants: Prof. Collins O. Airhihenbuwa, Pennsylvania State University, USA; M. Elaine Auld, Society for Public Health Education, USA; Barbara Battel-Kirk, National University of Ireland, Galway; Dr. Janet L. Collins, U.S. Centers for Disease Control and Prevention, USA; Prof. Randall R. Cottrell, University of Cincinnati, USA; Dr. Jerome Foucaud, Institut National de Prévention et d'Éducation pour la Santé, France; Alison Gehring, Royal Society for the Promotion of Health, UK; Jenny Griffiths, Royal Society for the Promotion of Health, UK; Emmanuelle Hamel, Institut National de Prévention et d'Éducation pour la Santé, France; Dr. Elizabeth H. Howze, U.S. Centers for Disease Control and Prevention, USA; Laura Rasar King, Council on Education for Public Health, USA; Marie-Claude Lamarre, International Union for Health Promotion and Education, France; Dr. William C. Livingood, Duval County (Florida) Health Department, USA; Linda Lysoby, National Commission for Health Education Credentialing, Inc., USA; Prof. Gudjon Magnusson, Reykjavik University, Iceland; Dr. David V. McQueen, U.S. Centers for Disease Control and Prevention, USA; Prof. Kathleen R. Miner, Emory University, USA; Prof. Maurice B. Mittelmark, University of Bergen, Norway; Martha Perry, International Union for Health Promotion and Education, France; Dr. Keiko Sakagami, Japanese Society for Health Promotion and Education, Japan; Dr. Arantxa Santa-Maria Morales, Madrid Regional Health Authority, Spain; Viv Speller, University of Southampton, UK; Prof. Alyson Taub, New York University, USA; and Dr. Lynn D. Woodhouse, Council of Accredited MPH Programs, USA.

NOTE: Affiliations are for purposes of identification only. The views expressed by the Galway Consensus Conference do not necessarily represent the views of the academic institutions, professional associations, accrediting bodies, or government or nongovernmental agencies with which meeting participants of the Galway Consensus Conference are affiliated or were affiliated at the time and are not meant to imply any official endorsement of the findings or recommendations of the Galway Consensus Conference.

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