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# CompHP

DEVELOPING COMPETENCIES AND  
PROFESSIONAL STANDARDS FOR HEALTH  
PROMOTION CAPACITY BUILDING IN EUROPE

## Literature Review

### Developing Competencies for Health Promotion

### Deliverable 3B

## Workpackage 4

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Executive  
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Health and  
Consumers



**NUI Galway**  
**OÉ Gaillimh**

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The views in this paper represent those of the authors.

## INTRODUCTION

This literature review forms part of the work of the project entitled 'Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe (CompHP). The CompHP Project <sup>1</sup> aims to identify, agree and publish core competencies for health promotion practice, education and training in Europe. This review provides an overview of the international and European literature published on the development of competencies for health promotion, with reference to work in related fields. The methodologies and processes commonly used in the development of competencies are reviewed. The evolution of health promotion and how it is currently practiced and by who, and the differences between countries regarding the understanding and practice of health promotion, public health and health education is also addressed in the context of identifying and agreeing core competencies. Contextual and critical issues arising in this field of work are outlined and discussed. The findings of the review will form the basis for developing a framework and a consensus building process for health promotion competencies development in Europe.

### Background to the CompHP Project

The CompHP project, which is funded by the Executive Agency for Health and Consumers (EAHC) <sup>2</sup>, aims to develop competency-based standards and an accreditation system for health promotion practice, education and training that will positively impact on workforce capacity to deliver public health improvement in Europe. The project takes a consensus building approach and aims to work in collaboration with practitioners, policymakers and education providers from across the geographical spread in Europe. Bringing together 22 partners with experience across the professional development, policy, practice and academic sectors, the project will develop, test and refine the implementation of a sustainable competency-based system in countries with varying levels of infrastructure development (from developed to virtually non-existent). This initiative builds on the work of the International Union of Health Promotion and Education (IUHPE) European Regional Sub-Committee on Training, Accreditation and Professional Standards which, under the leadership of the Vice President for Capacity Building Education and Training, sought to develop a pan-European competency framework for health promotion. The project was informed by a Europe-wide scoping study (Santa-María Morales and Barry, 2007) and feasibility study (Battel-Kirk and Barry, 2009) on implementing a competency-based accreditation system undertaken by IUHPE EURO. A set of core competencies, professional standards and a coordinated quality assurance accreditation system for health promotion will be developed and disseminated by the project.

The rationale for the CompHP project lies in the fact that health promotion is an evolving field in Europe with a diverse and growing workforce drawn from a broad

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<sup>1</sup> <http://www.iuhpe.org/index.html?page=614&lang=en>

<sup>2</sup> <http://ec.europa.eu/eahc/>

range of disciplines. Despite this diversity, however, it is recognised that there is a specific body of skills, knowledge and expertise that represents, and is distinctive to, health promotion practice (Allegrante et al., 2009; Barry et al., 2009). The development of the health promotion workforce internationally has brought renewed interest in identifying competencies for effective health promotion practice and education. Within the context of capacity building and workforce development, the identification of core competencies offers a means of developing a shared vision of what constitutes the specific knowledge and skills required for effective health promotion practice. A competent workforce with the necessary knowledge, skills and abilities in translating policy, theory and research into effective action is critical to the future growth and development of global health promotion (IUHPE, 2007; Barry, 2008; Battel-Kirk et al., 2009, WHO, 2009).

### **Aims and Objectives of the Literature Review**

This literature review forms part of the core work of the CompHP project, that of developing core competencies for health promotion. In Workpackage 4 of the CompHP project, it was agreed that a review would be undertaken of existing systems, publications and reports on the development of competencies in health promotion and related fields. The aim of the review is to identify the international literature published between 1980-2009 and to review the grey literature<sup>3</sup> available from the EU member states. The review includes reports, articles and other information sources within Europe and globally published between 1980 and 2009. While the review mainly focuses on literature produced in English during this period, it also aims to access relevant material in other languages where translation is available through the project partners. The results of this review will inform the initial draft of the core competencies which will be used to reach a shared understanding of, and consensus on, the core competencies required for health promotion practice, education and training in Europe.

### **Methods Used**

The review commenced in September 2009 and draws on previous reviews of the literature on competency development in health promotion, health education and public health and on the experience of the CompHP partners in developing competencies for health promotion. The scope of the review is limited to information on competencies that are available in English or that could be translated into English. Literature sources were found through a search of online databases including the following:

- Cochrane Library
- CDC
- Google Scholar Medline

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<sup>3</sup> **Grey Literature** is the term used for documents and ephemeral material issued in limited amounts outside the formal channels of publication and distribution. <http://www.biblio.uottawa.ca/content-page.php?g=en&s=rgn&c=src-litgris#def>

- HP-Net source
- Medline Plus
- NHS National Institute of Health Research through the University of York
- NUI Galway E Knowledge
- Pubmed
- Science Direct
- Scopus
- Skills For Health
- Springer Link
- US Mental Health and Substance Abuse
- Web of Knowledge
- Web of Science.

Search criteria included using the terms:

- health promotion competencies
- public health competencies
- capacity building in health promotion
- health promotion in 'country'.

Criteria for documents for inclusion were papers that addressed:

- Health promotion competencies
- Health education competencies
- Public health competencies
- Capacity building in health promotion
- Developing professional competencies
- Developing professional standards.

To supplement the online search of published material, the CompHP project partners were asked to submit any literature from their country, both published and unpublished, regarding the development of health promotion competencies and other related topics. Contacts from other European Union (EU) countries not represented by a partner in the CompHP project were identified either through HP-Net<sup>4</sup>, previously published material or previous participation in the development of health promotion and/or public health competencies. These contacts were asked to submit any literature relevant to health promotion competencies, competencies in other related fields such as public health and capacity building from their respective country.

The findings from all sources listed above are analysed in terms of the existence of competencies, methodologies used in their development, content of completed competency frameworks, and relevant contextual issues such as government policy and health structures. It should be noted that this review is confined to the sources of literature that were available, or made available in English.

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<sup>4</sup> <http://www.hp-source.net/>

## DEVELOPING HEALTH PROMOTION COMPETENCIES

Competency models have been increasingly used over the last 30 years to clarify the specific requirements for health promotion, public health and, health education. A number of countries have made significant progress in delineating competencies for health promotion (Battel-Kirk et al., 2009), including Canada (Ghassemi, 2009; Hyndman, 2007; Moloughney, 2006), Australia (Australian Health Promotion Association, 2009; James et al., 2007; Shilton et al., 2001, 2006, 2008; Howat et al., 2000), New Zealand (Health Promotion Forum for New Zealand 2000, 2004; McCracken and Rance, 2000) and a number of countries in Europe (Santa-María Morales and Barry, 2007; De Castro Freire et al., 2007; Santa-María Morales et al., 2009), including the UK (PHRU, 2008; Health Scotland 2003, 2005; Skills for Health 2001, 2004), the Netherlands and Estonia (Santa-María Morales et al., 2008). Some exploration of competencies has also been undertaken in EU funded projects such as the European Masters in Health Promotion project (EUMAHP) (Colomer et al., 2002; Davies, 2003; Meresman 2003; Meresman et al., 2004) and PHETICE (Public Health Education in the Context of an Enlarging Europe)<sup>5</sup>. ASPHER (The Association of Schools of Public Health in the European Region)<sup>6</sup> is currently developing standards for public health practice which incorporate a health promotion competency sub-set.

Significant developments have also taken place in the USA, mainly focusing on health education (Gilmore et al., 2004, 2005) and related accreditation systems (AAHE 1999; NCHCEC, SOPHE, and AAHE, 2006). In Europe accreditation systems have been developed in the UK (Skills for Health 2001, 2004), Estonia and the Netherlands (Santa-María Morales et al., 2009). The Galway Consensus Conference Statement on Domains of Core Competency for Building Global Capacity in Health Promotion (Allegrante et al., 2009; Barry et al., 2009) adds a global perspective to the work on competencies, which along with the other country specific developments, provides a useful base for informing the development of a competency framework in Europe.

Overall, the literature indicates that competencies have been shown to provide a useful base for health promotion training, academic preparation, and continuing professional development. However, it is clear that there is also considerable variation in the understanding and application of the competency approach in health promotion and related fields. These issues, together with an exploration of existing competencies in health promotion, will form the main focus of this section of the review. Reference will also be made to competencies in related fields such as public health and health education.

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<sup>5</sup> <http://www.phetice.org>

<sup>6</sup> <http://www.aspher.org>



### **What are competencies and why are they important?**

Competencies have been increasingly used in education and the labour market since the 1970s, when psychologists suggested the importance of testing for competency rather than intelligence. As a relatively new concept it has engaged the interest of academics and practitioners, particularly of those working in professions that have been affected by technological, organisational or cultural changes. It is accepted that a competencies approach can be helpful to describe sets of tasks, performances, skills and abilities in real-life work situations (Meresman et al., 2004). The concept of competencies in education has been an important reference to clarify expectations and define future professional needs for graduates, and provides a focus point for the development of curriculum and course design (Kosa and Stock, 2007).

There is no agreement on the usage of the terms competence or competency and they are often used synonymously (Battel-Kirk et al., 2009). There is also little agreement on the precise meaning of competencies but generally there are some common features. Kosa and Stock (2005), for example, cite a definition of competence in the educational context by Irigoin and Vargas (2002) as; *“the combination of knowledge, skills and attitudes conducive to an adequate performance in a given field”*. The Professional and Academic Standards Working Group of the European Masters in Health Promotion (Meresman et al., 2003) described competencies as; *“the knowledge, abilities and attitudes needed to implement specified health promotion actions within specified dimensions according to a specific standard”*.

Bowen-Clewley et al., (2005) defined competency as *“the ability to apply particular knowledge, skills, attitudes, and values to the standard of performance required in specific context”*. In the US competency is defined as *“an ability to apply a certain specific skill in dealing with some defined amount of meaningful subject matter”* (National Commission for Health Education Credentialing, 1996). According to Meresman et al., (2004) competence is not only knowledge, but also skills and attitudes needed to produce a performance. Competence is doing and acting so that a competent person not only knows something, but also knows how to do something with what they know.

Amatetti and Carnes (2009) articulated a framework where they defined competencies as *“a set of related knowledge, skills, attitudes/attributes (KSAAs) that are necessary to successfully perform job duties and responsibilities”*. Knowledge, in this context, refers to what someone knows (facts, research and principles) and it may be acquired and applied in a variety of settings, for example, through education and training or in the workplace. Skills are described as what someone does and the specific proficiencies and techniques that enable individuals to deliver effective services. Attitudes and attributes are defined as a person's perspective and personal qualities which include empathy and support, and attributes are personal characteristics such as respect and recognition. These definitions highlight that competencies refer not only to knowledge, but also to skills and attitudes, often referred to as 'know how' and 'show how' – a common format found throughout the international literature.

The definition of competencies agreed by the project partners for use in the CompHP project is that articulated by Shilton (2001): *“a combination of attributes such as knowledge, abilities, skills and attitudes which enable an individual to perform a set of tasks to an appropriate standard”*.

Core competency development is widely used in workforce initiatives to identify the essential elements for effective performance. Characteristics of core competencies are that they provide a set of unifying principles, are pervasive in all strategies and that they are rare and/or difficult to imitate (Prahalad and Hamel, 1990). Efforts to expand capacity to meet the needs of the population are reported as requiring a workforce with sufficient competencies to address the challenges faced (Ameretti and Cairnes, 2009). Competencies which are specific to health promotion, therefore, need to be based on the core concepts, principles and actions of health promotion as articulated in the Ottawa Charter (WHO, 1986,) and subsequent World Health Organisation (WHO) declarations.

The term core competencies as used in the CompHP project are defined as: *“the minimum set of competencies that constitute a common baseline for all health promotion roles. They are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field”* (adapted from the Australian Health Promotion Association, 2009).

The global development of core competencies has been uneven, however, as many countries lack the resources and support needed for building capacity and the development of health promotion training and professional practice. Despite these challenges, there is growing international support for the development of a core set of competencies for the health promotion workforce. It is recognised that competencies have a key role to play in:

1. Underpinning future developments in health promotion training and course development
2. Continuing professional development
3. Systems of accreditation and development of professional standards
4. Consolidation of health promotion as a specialised field of practice
5. Accountability to the public for the standards of health promotion practice.

Health promotion core competencies may be used for a range of purposes including to:

- Ensure there are clear guidelines for the knowledge, skills, attitudes, and values needed to plan, implement and evaluate health promotion efficiently, effectively and appropriately
- Assist employers/managers to develop relevant job descriptions and a better understanding of health promotion roles in individual workplaces
- Provide a tool for use in career planning and deciding on professional development and training needs
- Provide more opportunities for movement across roles and organisations within the health sector
- Integrate training with the daily activities carried out in the work setting

- Shape training programmes and qualifications to make them more relevant for the work carried out in the field
- Make performance appraisal processes more relevant and transparent
- Promote better communication and team work in multidisciplinary projects by providing a common language and shared understanding of key concepts and practices used in health promotion and
- Contribute to greater recognition and validation of the value of health promotion and the work done by health promotion practitioners.

Core competencies need to be regularly reviewed and updated in response to changes in contemporary practice, new health needs and policy contexts. In addition, competencies may also be used as the basis for the development of standards and quality assurance mechanism, such as the certification of individual practitioners and accreditation of academic professional preparation programmes (Taub et al., 2009).

### **The Evolution of Health Promotion: Context for Competencies Development**

By most accounts the field of health promotion as we currently know it began to emerge in the latter half of the 20<sup>th</sup> century, drawing on earlier developments in the public health movement and in health education. In 1948 the WHO defined health as a “*state of complete, physical, social and mental well-being, and not merely the absence of disease or infirmity*” (WHO, 1948). This was the first time that health was defined as a positive concept, and not merely the absence of illness. This holistic definition of health provided the basis for the features and values that have come to characterise health promotion. The Lalonde Report *A New Perspective on the Health of Canadians* (1974) is frequently seen to be the starting point of this new approach to health. This report argued that the major causes of death and disease lay beyond the biomedical model and that in order to promote the health of populations consideration must be given to the environment, individual behaviours and lifestyles. The report advocated a broader social model of health and the adoption of the ‘health field concept’, which consisted of the relationship between the areas of human biology, environment, lifestyle and healthcare organisation. A universal framework for examining health problems and for suggesting courses of action needed for their solution was proposed and as these ideas were comprehensive they had a unifying effect, bringing together into one common front: health professionals, health services, the scientific community, educational system, governments (municipal, provincial, federal), business sector, trade unions, voluntary organisations and the Canadian people. The Lalonde report was very influential internationally and it has been claimed, laid the foundations for the development of the Ottawa Charter, which was published by the WHO in 1986.

A number of other critical influences in the emergence of modern health promotion include the publication of a series of landmark documents by the World Health Organisation, which reflected similar themes. The *Alma Ata Declaration on Primary Health Care* (1977) which strongly reaffirmed that health is a fundamental human right and that that attainment of the highest possible level of health was a world-wide social goal. It also highlighted the importance of promoting health and committed all member countries to the principle that there “*should be the attainment by all the*

*people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life”* (WHO, 1978). In its *Global Strategy for Health for all by the Year 2000* (WHO, 1981), the WHO positioned health at the centre of development policy and defined the goal of health policy as *“providing all people with the opportunity to lead a socially and economically productive life”*. Finally, with the publication of the *Ottawa Charter for Health Promotion* (WHO, 1986) health promotion as a concept and a new field of action for health was launched.

The Ottawa Charter (WHO, 1986) drew on, and expanded earlier developments and is recognised as the seminal statement on health promotion. The Ottawa Charter (WHO, 1986) conceptualised health as a ‘resource for living’ and shifted the focus from disease prevention to ‘capacity building for health’ (Brewslow, 1999). In many parts of the world, health promotion has come to be understood not only as an approach that moves ‘beyond health care’ but also as a commitment to social reform and equity (Kichbusch, 2003). The development of the Charter was spearheaded by the WHO European Research Regional Office and was developed over a period of five years of intense research and debate. Health promotion was defined as *“the process of enabling people to increase control over and to improve their health”* (WHO, 1986). Health promotion is viewed as not only the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. Health promotion, therefore, represents a comprehensive social and political process, which not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health (WHO, 1986). The pre-requisites identified for health identified in the Charter are; peace, adequate economic resources, food and shelter, a stable eco-system and sustainable resources use. The Charter identified three key strategies for health promotion practitioners:

- Advocacy - to create the essential conditions for health
- Enabling - facilitate people to achieve their full potential
- Mediating – between the different in interests in society in the pursuit of health.

In addition to these strategies, five key action areas are identified for improving the health of populations (WHO, 1986; Kicksusch, 2003). These actions are considered to be integral to health promotion practice:

- Build healthy public policy - health promotion goes beyond health care and puts health on the agenda of policy makers in all sectors and at all levels directing them to be aware of the health consequences of policy decisions
- Create supportive environments – embraces the socio-ecological approach to health where the societies in which people live and work must be able to support healthy choices in order for people to achieve health
- Strengthening community action – empowering and enabling communities to improve their health by becoming involved in setting priorities, making decisions, planning strategies and implementing them to achieve better health

- Develop personal skills – health promotion supports personal and social development through providing information, education for health and enhancing life skills
- Reorient the health services – responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The Ottawa Charter embraces a socio-ecological model of health and seeks to address the wider determinants of health, particularly health inequalities. Those actively engaged in health promoting roles are encouraged to act as *advocates*, ensuring that the conditions favourable to health are in place, as *enablers* to facilitate populations groups to achieve their fullest health potential and to overcome health inequalities and finally as *mediators*, to arbitrate between differing interests in society for the pursuit of health. These remain important health promotion roles in addressing the political and economic challenges facing the promotion of global health (Scriven and Garman, 2005).

The Ottawa Charter formed the basis for international discussion of, and action on, health promotion. In overcoming an individualistic understanding of lifestyles and in highlighting social environments and policy, the orientation of health promotion began to shift from focusing on the modifications of individual risk factors or risk behaviours to addressing the ‘context and meaning’ of health actions and the determinants that keep people healthy (Kickbusch, 2003). Aspects of health promotion have been further defined and delineated in successive declarations and charters developed at four yearly WHO Health Promotion gatherings. Building healthy public policy which was explored in greater detail at the conference in Adelaide in 1988. The recommendations called for a political commitment to health by all sectors (WHO, 1988). The Sundsvall Declaration (WHO, 1992) provided impetus for WHO’s healthy settings approach, which now represents one of the key strategic approach by which health promotion is delivered in most European contexts (Orme et al., 2007). The Jakarta Declaration on Leading Health Promotion into the 21<sup>st</sup> Century (WHO, 1997) identified that poverty was the greatest threat to health and also noted the dangers to health posed by globalisation and environmental degradation. Bridging the equity gap both within and between countries was the special focus at the conference in Mexico (WHO, 2000). In 2005 Bangkok Charter for Health Promotion in a Globalised World (WHO, 2005) affirmed that policies and partnerships that are organised to empower communities and to improve health and health equity, should be at the centre of global and national development efforts. Most recently the 7<sup>th</sup> Global conference held in Nairobi in 2009, provided the first opportunity for global health promotion policy to be considered on the African continent (Catford, 2010). The conference closed with the adoption and declaration of the Nairobi Call to Action (NC2A) which reflected the collective views of over 600 international participants from more than 100 countries. Using multiple participatory processes, the Call to Action identified key strategies and commitments urgently required to close the implementation gap in health, health inequities and development through health promotion (WHO, 2009).

The NC2A outlines five urgent responsibilities for governments and stakeholders as being to:

- Strengthen leadership and workforces
- Mainstream health promotion
- Empower communities and individuals
- Enhance participator processes
- Build and apply knowledge (WHO, 2009).

### **Health Promotion in the Context of Public Health and Health Education**

While the focus within the CompHP Project is on health promotion as defined in the Ottawa Charter, it is necessary to refer to public health and health education when exploring policy, practice and education in a pan-European setting and in reviewing competency development globally. This is the case as there are differences in terminology between countries and in some, titles and job descriptions may not include 'health promotion' although it may be reflected in actual practice. Even where there are distinct practice boundaries between the three areas, there is shared history and a shared common goal of improving health, even if the approaches and methods used differ.

The position of health promotion in relation to other health improvement disciplines is thus an area of ongoing debate. For some the 'new public health' has subsumed health promotion into a multidisciplinary public health framework while others argue that health promotion is a distinct area of practice. The relationship between health promotion and health education is also contentious, with some using the terms interchangeably and others emphasise differences of approach, principles and effectiveness of each. The terms can mean different things to different people in different contexts and indeed in different countries. Davies (2003), for example, states that in the United Kingdom (UK) over the past decade they have witnessed a plethora of new terms related to the promotion of health such as 'health improvement', 'health development', 'healthy lifestyles', 'health action', 'health investment', for example.

Health is a contested concept that means different things to different people and the relationship between health promotion and public health is also contested. The emergence of health promotion as a concept distinct from traditional public health practice or disease prevention took place in the 20<sup>th</sup> century. Health promotion and public health are, however, often seen as complementary and overlapping areas of practice in many countries (Naidoo and Wills, 2005). Some health promotion competency frameworks, e.g. in Canada, have been developed in association with similar frameworks in public health and recent global endeavours have attempted to develop domains of core competency for both health education and health promotion. It can also be argued that competencies developed in other related fields, such as population health, community health development, cultural competencies for health, also have relevance to the development of a competency framework for health promotion.

It is useful to examine some international reports and statements on health promotion to attempt to define its boundaries and explore the differences in interpretation in different contexts and countries. The Ottawa Charter (WHO, 1986) positions health promotion as 'focusing attention on public health issues' and as including 'reorienting health services' but is otherwise non-specific on the relationship to public health according to Scott-Samuel and Springett (2007). In an analysis of understandings of health promotion in relation to public health, Scott-Samuel and Springett (2007) contrast the Tannahill model (Tannahill, 1985) of health promotion, which places health promotion within public health, of which it is said to constitute 'a substantial and vital component' (Downie et al., 1990) to Tones (1990) who considers that health promotion incorporates all measures deliberately designed to promote health and handle disease thus placing public health within health promotion. Scott-Samuel and Springett (2007) described health promotion and public health in terms of separate but overlapping domains, linked respectively to social and medical models. The health promotion model is depicted as a social model of health, which embraces advocacy, healthy public policy development, community development, organisation development and health impact assessment. In contrast, the public health medical model of health is described as focusing on preventive medicine, communicable disease control, environmental health and healthcare effectiveness. The overlap between the two models contains health education, health strategy, legislation and social epidemiology. This description reflects the continuing dominance of public health medicine and epidemiology in public health as practiced in many countries.

#### *Health Promotion and the New Public Health*

The public health movement had its origins in the nineteenth century. This began as a means of improving living conditions, particularly in urban areas, and it emphasised issues such as sanitation and infectious disease control, and the regulation of environmental and housing conditions. Traditionally public health has meant disease prevention and this method required a knowledge of medical conditions and an ability to assess and monitor disease trends. In many Western countries, therefore, public health has developed as a speciality of medicine (Naidoo and Wills, 2005).

In his 1988 report *Public Health in England: The Report of the Committee of the Inquiry into the Future Development of the New Public Health Function*, Acheson defined public health as "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society". Baum (1998) describes the shift that took place in the 1980s in moving from the predominance of the medical model towards the socio-environmental model of public health and acknowledges that the move towards the new public health approach was viewed as the one most likely to achieve genuine, sustainable, health improvement. The term 'New Public Health' is used to reflect this broader, social view of public health.

A distinction is, therefore, made between traditional public health, which is more closely aligned with disease prevention and the new public health for the purposes of emphasising significantly different approaches to the description and analysis of the determinants of health, and the methods of solving public health problems. The new public health is distinguished by its basis in a comprehensive understanding of how lifestyles and living conditions determine health status, and recognition of the need to

mobilise resources and make sound investments in policies, programmes and services, which create, maintain and protect health by supporting healthy lifestyles and creating supportive environments for health (WHO, 1998). Health promotion was envisaged as a dynamic force within this new public health movement, embracing a socio-ecological model of health based on the dynamic exchange between people and their environments, leading to integrated interventions (Ashton and Seymour, 1988) and *“synthesising personal choice and social responsibility in health to create a healthier future”* (WHO, 1984).

Moving from distinct biomedical and social models of health, the concept of ‘multidisciplinary public health’ has gained currency in a number of countries, where it is used as an umbrella term to cover a broad range of functions including health promotion, prevention and protection activities. However, the move to multidisciplinary is perceived to have different impacts on the different constituent public health disciplines. This is evidenced, for example, by the Shaping the Future of Health Promotion Project in the UK (2005), which aimed to clearly define the roles, functions and professional development needs of those from a health promotion background working within the multidisciplinary public health workforce (Scriven, 2004). The report states that specialised health promotion is a discipline integral to public health and notes that in the UK health promotion has been eroded in recent years due to repeated organisational change, lack of focus and proactive advocacy, and that health promotion expertise needs to be encouraged within the public health workforce as a whole. According to Scott-Samuel and Springett (2007), the changing public health discourse has important ramifications for health promotion, both as a discipline and a practice, and for the nature of public health. Although the debate on the relationship between health promotion and public health is ongoing (Scriven and Garman, 2005), few would challenge the centrality of health promotion in public health or its contribution to the development of theory, research and practice in an evolving social model of health (Bunton and MacDonald, 2002).

#### *Health Promotion and Health Education*

Health education may be defined as a discipline that comprises consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, improving knowledge, and developing life skills which are conducive to individual and community health (Nutbeam, 1998).

Health education is another area where there can be confusion between it and health promotion. Health education includes the communication of information concerning the underlying social, economic and environmental conditions impacting on health, as well as individual risk factors and risk behaviours and issues of the health care system (Nutbeam, 1998). Health education is not only concerned with the communication of information, but also with fostering the motivation, skills and confidence (self-efficacy) necessary to take action to improve health. In the past health education was used as a term to encompass a wider range of actions including social mobilisation and advocacy (Nutbeam, 1998). In this context health education is the process of educating people about the factors that impact on their health and teach them the strategies and skills to make the choices that can impact positively on their own health.



Tones (1997) distilled the relationship between health promotion and health education into a formula where [health promotion = health education x healthy public policy]. The Institute of Health Promotion and Education say that there is an accepted differentiation between health education and health promotion. Health education is defined as the intervention on a personal level, whereas health promotion is considered to be concerned with interventions on a population level<sup>7</sup>.

In the US, the Joint Committee on Health Education Terminology (2002) defines health education as: *“a practice that uses multidisciplinary theories and behavioural and organisational change principles to plan, implement, and evaluate interventions that enable individuals, groups and communities to achieve personal, environmental, and social health”*. Health education in the US is a distinct profession, recognised by the US Department of Labour, with formal academic preparation programmes at the baccalaureate, master’s and doctoral degree levels.

The term health promotion, as drawn from the Ottawa Charter, is used widely in many countries as an overarching concept that encompasses health education as one of its implementation strategies alongside, for example, creating supportive environments and healthy public policy. In other countries like the United States and countries in South America, the term health education is also used to encompass these broader strategies. Based on historical, cultural, and political considerations, there is a preference for the use of either the term health promotion or the term health education to identity professional practice in a particular country (Taub et al., 2009). However, there can be intrinsic differences in meaning of the terms as used in relation to the focus of practice.

#### *The Practice of Health Promotion*

The principles of health promotion practice as articulated in the Ottawa Charter for Health Promotion (WHO, 1986), are based on an empowering, participatory and collaborative process, which aims to increase control over health and its determinants. As described by Kickbusch (2003), the Ottawa Charter initiated a redefinition and repositioning of actors at the ‘health’ end of the disease-health continuum. This reorientation shifts the focus of practice from the modification of individual disease risk factors or risk behaviours to addressing the contexts and meaning of health action and the protective and enhancing factors that keep people healthy. The inextricable link between people and their environments, which is where health is created, forms the basis of this socioecological approach to health and provides a distinctive conceptual framework for practice.

Health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (Raphael, 2000; IUHPE, 1999) based on well-developed strategies, theories, evidence, and values that collectively constitute a guide to good practice in health promotion (Kahan and Goodstadt, 2001; McQueen and Jones, 2007).

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<sup>7</sup> <http://www.ihpe.org.uk/home/index.htm>

Health promotion is guided by a set of core values and principles (Allegrante et al., 2009) including:

- A social-ecologic model of health that takes into account the cultural, economic, and social determinants of health
- A commitment to equity, civil society and social justice
- A respect for, and sensitivity to, cultural diversity
- A dedication to sustainable development
- A participatory approach to engaging the population in identifying needs, setting priorities, and planning, implementing, and evaluating the practical and feasible health promotion solutions to address needs.

The WHO (1986) described the following key principles for health promotion practice:

- Whole population approach involves the population as a whole in the context of their everyday life, rather than focusing only on people at risk for specific diseases or disorders
- Focus on risk and protective factors for enhancing well-being and quality of life
- Action on the determinants of health by focusing on the social, environmental, economic conditions that are the root causes of health and illness and that determine the health status of individuals or populations
- Comprehensive, intersectoral initiatives extending beyond the health services which involves utilising a range of different, but complementary methods and approaches including education, legislation, fiscal measures, community development and communication
- Interventions to promote behavioural, socio-environmental and policy change
- Effective public participation, supporting people in their communities and encouraging people to find their own way of managing the health of their communities.

The following core values, as articulated in the Health for All strategy, also provide an important base for the development of health promotion strategies:

- Health as central to human development
- Social justice to ensure that everyone has equitable access to food, income, employment, shelter, educational and other factors needed to maintain good health
- Empower people to take control over their health and its determinants
- Active participating communities
- Healthy public policy
- Health promoting environments
- Intersectoral action and partnerships with the non-health sector
- International collaboration.

Health promotion practice focuses on the broad determinants of health and health inequity. This includes addressing those determinants within the control of individuals, such as individual health behaviours and the use of health services, and others which are outside the control of individuals, such as social, economic and environmental

conditions. Thus, actions which support people to adopt and maintain healthy lifestyles, and which create supportive living environments for health are key elements of effective health promotion practice (IUHPE, 2000).

A key feature of health promotion practice is the use of participatory and empowerment approaches. Empowerment is defined as a process through which people gain greater control over the decisions and actions that affect their health (Nutbeam, 1998). In this way health promotion addresses health issues by doing things with people rather than to them or for them. The central idea of an empowerment 'process' is that it refers to a bottom-up participatory approach which takes as its starting point how health and its determinants are perceived by the individual, group or community itself (WHO, 1998; Tengland, 2009). This approach is perhaps the most important feature of health as it embodies the key health promotion values of empowerment, social justice and equity, inclusion and respect.

Health promotion is also concerned with developing and implementing healthy public policy and strengthening community action through working with community and voluntary groups, existing services and community leaders, building on existing strengths and assets to enhance self-help and social support, and to develop flexible systems for strengthening public participation in, and direction of, health matters (WHO, 1986).

As outlined earlier, health promotion underscores the importance of synergistic action highlighting the need for top-down policy approaches and bottom-up community action working together to achieve common goals. Health promotion actions as outlined in the Ottawa Charter (WHO, 1986) require using multiple, complementary strategies. The five key action areas of; building healthy public policy, creating supportive environments, strengthening community action, developing personal skills and re-orienting of the health services, continue to provide a blueprint for health promotion practice. Reviews of health promotion interventions indicate that the most effective interventions employ a combination of these integrated strategies operating at the multiple levels of structural, community and individual determinants of health (Jackson et al., 2005).

Contemporary health promotion draws on a range of theoretical and disciplinary perspectives and operates at many levels to facilitate conditions and opportunities for personal, community and organisational empowerment, effective partnerships and alliances, healthy public policy and reorientated, sustainable environments. This can be conceptualised either in terms of policy and practice area, or in terms of the philosophical and disciplinary roots that have informed and driven health promotion theory and practice (Orme et al., 2007).

#### *Who are the Health Promotion Workforce?*

The health promotion workforce includes a broad the range of people and agencies who work to promote health. The Ontario Health Promotion Resource System (2005) employs the following definition; *"health promoters include those who work to promote health as defined in the Ottawa Charter regardless of professional designation. It includes people, organisations, and groups from various sectors.*

*Health promotion work may be paid or voluntary". According to Hyndman (2009), "health promoters should be able to assess the nature of a health issue or problem and provide analysis and advice on how to address it through the appropriate mix of health promotion strategies, including community mobilisation, health education, advocacy, policy development and organisational change. This skill set constitutes the 'value added' that health promoters bring to the field of public health".*

Promoting health may include a broad range of workers, however, it is increasingly common in many countries for health workers to have health promotion identified as an aspect of their role. There is also a body of professionals who are deemed health promotion 'specialists' by virtue of their dedicated training (graduate or postgraduate qualification), specialist functions and experience in health promotion. Health promotion is a clearly defined function in a number of countries and is open to people from diverse disciplinary backgrounds who have acquired specific education and training in health promotion and ongoing professional development to maintain levels of knowledge.

Taub et al., (2006) point to the distinction often made between health promotion specialists or designated health promotion professionals (i.e. those who have health promotion in their job title), and the wider health promotion workforce. Therefore, the definitions of the roles and responsibilities and related levels of knowledge and skills required for these different levels of practice are likely to differ considerably and need to be considered. To date, efforts to delineate competencies, for example in Australia, Canada, the Netherlands and the United Kingdom, usually have been developed for health promotion specialists but have highlighted that these developments are not intended to exclude the wider health promotion workforce.

Some countries, such as the United States and Australia, have evolved clearly defined career pathways and models of academic training and professional preparation programmes for health education and health promotion specialists. In contrast, many countries in Europe and elsewhere do not embrace health promotion, as a specialised area of practice but rather have sought to encapsulate these functions under the broader umbrella of the multidisciplinary public health profession (Taub, 2009). Thus, the cultural variations in the roles of medicine, public health, and health promotion and health education in various countries have in turn, influenced concepts of professional practice, professional preparation, and professional authority and autonomy (Taub, 2009).

The level of professionalisation of health promotion practice varies across countries as health promotion covers a wide range of activities from health promotion specialists playing leadership and technical expert roles, through to health promotion generalists or practitioners, researchers and individuals from different professions whose work is based on a 'health promoting' perspective (Santa-María Morales and Barry, 2007). Despite this, there is undoubtedly a specific body of knowledge and skills, values and principles which informs and underpins health promotion and therefore makes this a distinctive area of practice.

At an international level there are a number of different organisations such as the World Health Organisation and European Union, that have a key role in advancing health promotion. Nationally and locally health promotion is generally the responsibility of the governmental Departments of Health working in close collaboration with the health services, non-governmental/voluntary organisations, academic departments, local governments and health agencies. Health promotion may not be a core activity of organisations such as the World Bank or the local authority but their activities can make a significant contribution to the promotion of good health in society (Naidoo and Wills, 2009). As a non-governmental organisation, the International Union for Health Promotion and Education (IUHPE), shares the responsibility with WHO and other government organisations and NGOs for the global development of health promotion. The IUHPE is a worldwide, independent and professional association of individuals and organisations committed to improving the health and wellbeing of the people through education, community action and the development of healthy public policy. The IUHPE mission is to promote global health and wellbeing, and to contribute to the achievement of equity in health between and within countries of the world. The IUHPE fulfils its mission by building and operating an independent, global, professional network of people and institutions to encourage the free exchange of ideas, knowledge, know-how, experiences, and the development of relevant collaborative projects, both at global and regional levels. To achieve these goals the IUHPE pursues a wide range of activities through its global and regional work plans<sup>8</sup> and provides global network for mutual support and professional advancement of its members.

## **CAPACITY BUILDING AND COMPETENCIES IN HEALTH PROMOTION**

Building capacity to improve health is recognised as an important element of effective health promotion. Building capacity increases the range of people, organisations and communities who are able to address health needs and particular, problems that arise out of social inequity and social exclusion (NSW Health, 2001). McClean et al., (2005) state that capacity refers to the qualities or characteristics that enable people to do something. They observe that the capacity to act is not only determined by the qualities and characteristics of individuals but that the individual's capacity to act is mediated by their environment. Therefore when considering capacity for complex professional practices such as health promotion, it is important to note that the environment involves not only the immediate organisational setting within which individuals work but also a broader social context within which both the individual and their organisation exist. Building capacity means developing the qualities and characteristics of the individual, and shaping the organisational and social environment within which that individual will act (McLean et al., 2005).

Health promotion capacity building has been defined as *“an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over”* (Hawe et al., 1997). Capacity building as a set

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<sup>8</sup> [www.iuhpe.org](http://www.iuhpe.org)

of strategies can be applied not only within programmes but also across systems to lead to greater capacity of people, organisations and communities to improve health. Building capacity involves working on multiple levels as people, organisations and communities do not exist in isolation but instead each part is affected by the other. *The Framework for Building Capacity to Promote Health* (NSW Health, 2001), highlights five key action areas to guide the capacity building effort: organisational development, workforce development, resource allocation, leadership and partnerships (NSW Health, 2001; Heward et al., 2007). It can be argued that, while the major impact of competencies will be on workforce development, they will also have an impact on all of these action areas.

Capacity building to support the development and implementation of policy and best practice is key to the future growth and development of health promotion. As health promotion makes its way onto the policy agenda in many countries, it is timely to consider what infrastructure is required for the sustainable implementation of effective practice for the future (Barry, 2008). Global interest in workforce development, capacity building, and quality assurance in health promotion and education has increased during the past decade (Allegrante et al., 2009). Improving the quality of health promotion practice is at the core of this interest (Barry et al., 2009; Taub et al., 2009).

In order to achieve the global improvements in health that have been called for in the World Health Organisation Charters and declarations for Health Promotion from Ottawa (WHO, 1986) to Nairobi (WHO, 2009), the *UN Millennium Development Goals Report* (2007) and the *Commission on the Social Determinants of Health* (WHO, 2008), a global expansion of a competent health promotion workforce is required (Barry et al., 2009; Allegrante et al., 2009). Capacity building was one of the themes presented at the 7<sup>th</sup> Global Conference on Health Promotion in Nairobi<sup>9</sup>. The working group stressed the importance of reinforcing systems in terms of human resources, institutional structures, infrastructure and financial resources. *The Nairobi Call to Action* (2009) emphasises that sustainable health promotion infrastructure and capacity at all levels is fundamental to closing the implementation gap in health and development through health promotion. Strengthening leadership, adequate financing and growing the practitioner skill base, including setting accreditation competencies and standards for health promotion, are identified for action (WHO, 2009).

Building a competent health promotion workforce is also one of the priorities identified by the IUHPE in the report *Shaping the Future of Health Promotion: Priorities for Action* (IUHPE and Canadian Consortium for Health Promotion Research, 2007). This report states that workforce capacity and capability for health promotion is well developed in only a few countries, and under resourced or entirely lacking in many. In addition, it identifies that urgent and sustained action is required to strengthen the capacity of academic health promotion. Appropriate alliances are noted as being needed with professionals and academics from related fields that share the common

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<sup>9</sup> [http://www.gesundheitsfoerderung.ch/pdf\\_doc\\_xls/e/GFPstaerken/Netzwerke/Nairobi-Call-to-Action-Nov09.pdf](http://www.gesundheitsfoerderung.ch/pdf_doc_xls/e/GFPstaerken/Netzwerke/Nairobi-Call-to-Action-Nov09.pdf)

goal of promoting health, while acknowledging that health promotion is a distinct field and body of knowledge in its own right.

Barry (2008) identified two key areas that have been prioritised for action in the IUHPE Vice President for Capacity Building, Education and Training workplan:

- Workforce development in countries with identified capacity needs
- The development of international collaboration on core competencies for health promotion practice, education and training.

Workforce development is recognised as being critical to building capacity for the effective delivery of health promotion strategies. The need for a trained and competent workforce, which has the necessary knowledge, skills and abilities in translating policy objectives and current research knowledge into effective action, is a key component of the capacity needed by nations to promote the health of their populations (Wise, 2003; Barry, 2008).

Identifying and agreeing the core competencies for health promotion practice, education and training is a critical component of developing and strengthening workforce capacity to improve global health in the 21<sup>st</sup> century (Taub et al., 2009, Allegrante et al., 2009; Barry et al., 2009). Within the context of capacity building and workforce development, the identification of competencies offers a means of developing a shared vision of what constitutes the specific knowledge and skills required for effective health promotion practice (Battel-Kirk et al., 2009). It is also suggested that competencies can be used as a policy lever to ensure adequate workforce development funds are allocated (Redman and O'Hara, 2003).

## **The Global and European Context for Competency Development**

In considering the development of core competencies for health promotion, it is necessary to consider the broader context for health promotion at global, European, regional and national levels. This section will focus in particular on the global and European policy contexts for health promotion development and will overview some of the key initiatives in advancing the development of core competencies for health promotion in Europe.

### *The Global Context*

Health-related problems such as chronic diseases, infectious diseases, environmental threats and injuries continue to add to the global burden of disease. Many of these health problems are considered in some way preventable if the appropriate policies that support and maintain environments and the societal infrastructure necessary for the promotion of health are developed and enacted. Health promotion is a vital strategy for improving global health and has a central role to play in meeting the global commitment to reduce poverty by addressing the Millennium Development Goals (MDGs) and the recommendations outlined in the report of the World Health Organisation's Report, *Commission on the Social Determinants of Health* (CSDH, 2008). Human, social and financial resources will be needed, however, to make this role a reality, especially in countries where development has been lagging.

Health is regarded by the World Health Organisation as a fundamental human right and all people should have access to basic resources for health. The WHO recognises that, in order to achieve the global agenda for social progress, health is a necessary prerequisite. To achieve improvements in health the Ottawa Charter (WHO, 1986) identified the fundamental conditions and prerequisites that underlie health as: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. The social and economic determinants of health, and indeed the social conditions that must be created to promote health have not, it is suggested, been sufficiently addressed. While life expectancy and good health have increased in parts of the world they have failed to improve in others. There is increasing evidence that the gap that separates the health of the rich and the poor is widening, not only within countries but also between countries all over the world. These inequities in health, i.e. avoidable health inequalities, arise because of structural determinants such as social and economic policies, and conditions of daily life, which together constitute the social determinants of health (CSDH, 2008).

A comprehensive understanding of health implies that all systems and structures which govern social and economic conditions and the physical environment should take account of the implications of their activities in relation to their impact on individual and collective health and well-being (Nutbeam, 1998). The WHO established the Commission on the Social Determinants of Health in 2005 to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it. The Commission on Social Determinants of Health (WHO, 2008) report outlined three overarching recommendations for action in addressing health inequities:

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age
2. Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health, and raise public awareness about the social determinants of health.

This report endorses the fundamental role of health-care systems based on the principles of equity, disease prevention, and health promotion in addressing health inequities. The need to create the capacity to act effectively on health inequity is identified through building and strengthening the health workforce, and expanding capabilities to act on the social determinants of health. These points are further reinforced and elaborated in the *Nairobi Call to Action* (WHO, 2009) which outlines key strategies, including building the capacity and competency of the health promotion workforce, for closing the implementation gap in advancing global health and reducing health inequities.

The IUHPE, as part of its core mission to promote global health, has a clear commitment to contribute to the achievement of equity in health between and within countries of the world. In *Shaping the future of health promotion: Priorities for action*



(IUHPE, 2007) the main actions needed to ensure global health promotion and health equity in the 21<sup>st</sup> Century are outlined. Among the priority actions identified, alongside strengthening health promotion structures, policies and processes, is the importance of building a competent health promotion workforce for shaping the future of health promotion practice. Three key areas are identified:

1. The development of workforce capacity and capability for health promotion through further investment in the education and training of health promotion specialists, practitioners and other workers. Essential training should include: developing the knowledge and skills for advocacy and mediation with politicians and the private sector, assessing the impact of policies on health and its determinants, accessing and using available information and evidence and evaluating interventions
2. Urgent and sustained attention is required to strengthen the capacity of academic health promotion. Appropriate alliances are needed from related fields that share the common goal of promoting health, while acknowledging that health promotion is a distinct field and body of knowledge in its own right. Health education based on sound education principles and practice is an important integral health promotion strategy. It is recommended that closer links and coalitions be made with complementary disciplines such as public health and nursing et cetera, which contribute both conceptually and practically to health promotion
3. The recognition of specialist health promotion competence through professional accreditation schemes can be helpful to increase training and the visibility of the field, and extend the sharing of skills and knowledge more widely to others. Transnational agreement on health promotion core competencies is needed to further define the field and provide common direction for curriculum development.

These priority actions have subsequently been taken up by the IUHPE through the development of capacity building education and training initiatives on an international level, including the development of the Galway Consensus Statement, and at a European level through its involvement in a number of collaborative efforts, including the CompHP project.

#### *The European Context*

Out of the 47 European countries, 27 are members of the European Union with a total population of approximately 500 million people. Three other European countries are described as candidate countries and a number of other countries including Iceland have, or are actively considering, applying for membership. The citizens of the EU have never lived so long, and life expectancy is still increasing. However, the health of the EU population is far from being as good as it could be and there still remains a significant level of preventable morbidity and early mortality. The underlying social

and economic conditions and associated living and working conditions are identified as being the most important determinants of health in Europe<sup>10, 11</sup>.

The last decade has witnessed an unprecedented and rapid growth in the power and influence of the EU in the development of public health policy in Europe. From its early indirect responsibilities for factors influencing health, such as common standards related to medicines, health insurance, and the health of workers, the EU through the various European treaties, has become the driving force in facilitating action for the protection and improvement of health across Europe and beyond (Davies, 2003). This has an important impact on the need for, and the focus of, core competencies for health promotion in Europe.

The European Health Strategy, *Together for Health: a strategic approach for the EU 2009-2013*<sup>12</sup> includes action to promote good health by addressing the major determinants of ill health associated with morbidity and early mortality. In the European Union member states have the main responsibility for health policy and provision of healthcare to European citizens. It recognises that cooperative action at the Community level is indispensable and that cooperation and coordination among European countries and international organisations enhances the effectiveness of prevention policies. The EU supports the exchange of information and best practice guidelines, which allow the level of health protection to rise across the Community<sup>13</sup>.

To effectively implement this strategy there is a need for a skilled and professional health promotion workforce across member states with shared understanding of the core principles, knowledge and evidence base of health promotion, and the ability to translate the strategy objectives into practice. Building and enhancing capacity to deliver effective health promotion is crucial to health improvement and the reduction of health inequities in Europe and member states would benefit from a system that facilitates structured exchange, collaboration and coherence across diverse national structures in building the capacity of the health promotion workforce (Santa-María Morales et al., 2000).

Efforts to expand capacity to meet the needs of the population require a workforce with sufficient competencies to address the challenges faced. The identification of core competencies for health promotion in Europe offers a means of developing a shared vision of what constitutes the specific knowledge and skills required for effective health promotion practice in the European context (Battel-Kirk et al., 2009). In view of the different stages of health promotion development across Europe, it is reasonable to state there is a need for a coherent framework that will build on national and international developments and lead to a comprehensive and flexible system for workforce development and quality assurance (Santa-María Morales et al., 2009).

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<sup>10</sup> [http://epp.eurostat.ec.europa.eu/cache/ITY\\_OFFPUB/KS-QA-09-031/EN/KS-QA-09-031-EN.PDF](http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-QA-09-031/EN/KS-QA-09-031-EN.PDF)

<sup>11</sup> [http://ec.europa.eu/health-eu/health\\_in\\_the\\_eu/index\\_en.htm](http://ec.europa.eu/health-eu/health_in_the_eu/index_en.htm)

<sup>12</sup> [http://europa.eu/legislation\\_summaries/public\\_health/european\\_health\\_strategy/c11579\\_en.htm](http://europa.eu/legislation_summaries/public_health/european_health_strategy/c11579_en.htm)

<sup>13</sup> [http://ec.europa.eu/index\\_en.htm](http://ec.europa.eu/index_en.htm)

Within Europe there is a diversity of social, economic, cultural and political contexts and this diversity is reflected in the current development of health promotion capacity across member states. It is recognised, however, in EU policies and strategies that quality standards are the key to the ethical use of resources and effective action on health. The training of staff based on clearly defined standards and the implementation of quality governance standards are seen as important mechanisms in achieving quality practice. Over the last two decades the EU has issued a number of directives and decisions (Recognition of the Professional Qualifications, 2005/36/EC, Setting up a Group of Coordinators for the Recognition of Professional Qualifications, 2007/172EC) to establish more flexible systems for recognising professional qualifications and ensuring quality and access in health-related services, thus facilitating the principle of free movement across the member states. The transnational recognition of professional qualifications provides an impetus for developing common standards and quality criteria in the training and education of health professional, and from a health promotion perspective, all professionals with a health improvement remit (Santa-María Morales et al., 2009). These strategies and treaties, therefore, provide a powerful background context for the development of pan-European competencies for health promotion.

The Maastricht Treaty (Title XII, Education, Vocational Training, Youth and Sport Article 165 (ex Article 149 TEC) stated that the European Community should contribute to the development of quality education by encouraging co-operation between member states and supporting and supplementing that action when necessary. Maastricht also stated that member states should encourage mobility of students and teachers by encouraging the academic recognition of diplomas and periods of study, promoting cooperation between educational establishments, and developing exchanges of information and experience on issues common to the education systems of the member states<sup>14</sup>. This obviously has direct relevance for the development of competencies that will form the basis of education and training in health promotion across Europe.

The overarching aim of the Bologna Process was to create a European Higher Education Area (EHEA) based on international cooperation and academic exchange that is attractive to European students and staff as well as to students and staff from other parts of the world. The Process is named after the Bologna Declaration, which was signed by 29 countries in June 1999. The signatories pledged to reform their higher education systems in a convergent way to make European Higher Education more compatible and comparable, more competitive and more attractive for Europeans and for students and scholars from other continents<sup>15</sup>.

The objectives of this Declaration were specifically to work towards a system of comparable degrees/qualifications, common cycles of undergraduate and postgraduates systems, a credit system (ETCS) based on volume of study, the encouragement of active mobility among both staff and students across Europe, promotion of cooperation in European quality assurance/common criteria

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<sup>14</sup> <http://eur-ex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2008:115:0047:0199:EN:PDF>

<sup>15</sup> <http://ec.europa.eu/education/policies/educ/bologna/bologna.pdf>

development and encouragement of the Euro-dimension of higher education such as curriculum development, inter-institutional cooperation, mobility schemes and integrated programmes of study and in-training and research (Davies, 2003).

Today, the Process unites 46 countries. An important characteristic of the Bologna Process, and the key to its success, is that it also involves the European Commission, Council of Europe and UNESCO-CEPTES, as well as representatives of higher education institutions, students, staff, employers and quality assurance agencies<sup>16</sup>.

On the basis of the Bologna Declaration, the European Association for Quality Assurance in Higher Education in Europe (2005) developed a set of standards and guidelines for the European higher education system and explored ways of ensuring an adequate peer review system for quality assurance and/or accreditation agencies. All of these developments provide a clear rationale for developing a pan-European mechanism to quality assure the professional preparation and qualification of those working in health promotion in EU member states (Santa-María Morales et al., 2009).

### **Collaboration on Health Promotion Competency Development in Europe**

The European Commission, through its public health programme, has supported a number of significant initiatives in this area. These include the development of competencies for health promotion postgraduate training in the European Masters in Health Promotion (EUMAHP) project (Colomer et al., 2002) and other collaborative initiatives such as the pan European competency development projects of PHETICE and ASPHER. We will now review the pan-European initiatives developed in recent years that have capacity building and competency development at their core.

#### *European Masters in Health Promotion (EUMAHP)*

The European Masters in Health Promotion is one of the European Commission funded initiatives, developed in relation to health promotion in Europe (Meresman, 2004). In 1997, a consortium of experts involved in health promotion training from all member states and Norway came together. The development of the EUMAHP Programme began in 1998 with the overall aim of improving the quality of health promotion through the professional training of health promoters in Europe and to benefit from the value-added aspect of the European dimension. The project also sought, 'to develop further and reinforce the European conceptualisation of health promotion post Ottawa Charter' (Colomer et al., 2002). The development of competencies was central to the initial work of the European Consortium of Masters in Health Promotion (EUMAHP) project (Davies et al., 2000). The aims of the EUMAHP competency project were:

- The aspiration to improve health promotion training standards in academic institutions

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<sup>16</sup> <http://www.ond.vlaanderen.be/hogeronderwijs/bologna/about/>

- The certification or accreditation of health promotion professionals and practitioners
- The professionalisation of the health promotion field and consolidation of its recognition.

Curriculum development for health promotion training was one of the main working areas of the Consortium, including a focus on quality assurance of relevant educational programmes. The development of a European core curriculum and competencies was central to the project's work (Davies et al., 2000). The EUMAHP Professional and Academic Standards Working Group defined competencies for health promotion as: 'the knowledge, abilities and attitudes needed to implement specified health promotion actions within specified dimensions of practice according to a specific standard' (Meresman et al., 2006). As part of the remit of this Working Group, a survey covering both generic health promotion and practice in specific settings and with particular groups of people was administered and completed by 33 health promotion experts from across Europe. Participants were asked to map the competencies they envisioned as most essential, desirable or not relevant. A total of 27 competencies were identified within the following five areas of competency:

1. Analytical competencies  
e.g. Understanding of social, cultural, and subjective determinants of health
2. Social management competencies  
e.g. sensitivity towards group and institutional dynamics. Ability to deal with such dynamics
3. Policy making competencies  
e.g. Understanding of public sectors, policies and services
4. Communication competencies  
e.g. Dialogue skills, active and careful listening, empathy, compassionate listening
5. Operational competencies  
e.g. Management skills: leadership, decision making, resource mobilisation skills, scheduling task. (See Appendix 1 for full list of competencies).

The EUMAHP framework for competencies, comprising the five dimensions above, formed the basis for developing a core curriculum for postgraduate training programmes published by the Consortium (Colomer et al., 2002). This seminal work provided an important foundation for the collaborative development of a coherent core curriculum for postgraduate training in health promotion across Europe.

#### *Public Health Training in the Context of an Enlarging Europe (PHETICE)*

Another EC funded project which focused on competencies as a basis for curriculum developed is the PHETICE project which developed a framework to guide the training of multidisciplinary public health workers and included health promotion experts in its steering group.

The PHETICE project was launched in 2005, with the notion that public health developments within the European Union required a unified approach to workforce development across the public health specialisations. It was considered that the

introduction of a common European dimension of public health was needed to meet the developments and use the framework set up by the European Commission.

The project was set up by five EC supported European Master Programmes in the wider area of public health, public health nutrition, gerontology, epidemiology and health promotion. The work performed within the PHETICE project include a mapping of the current situation of public health training and a gathering of relevant documents and information collected relevant information on how the joint European health monitoring system can be supported by training, and how competencies and quality assurance systems are being developed over Europe<sup>17</sup>

The PHETICE project was divided between seven different workpackages and distributed between five partners. Within the PHETICE programme, a mapping exercise of the current situation of public health training was performed in order to provide background information for the project. A gathering of relevant documents and information on higher education in public health in Europe. They also reviewed information on the educational and pedagogical strategies that are suitable for public health but also streamlined to fit with the Bologna process. Data was also collected on how the joint European health monitoring system could be supported by training, and how competencies and quality assurance systems are being developed throughout Europe. A survey was developed and it went to universities and schools of public health all over the enlarged Europe, using a joint address list from the Association of schools of Public Health (ASPHER) and the already existing European Master Programmes. A total of 86 universities responded (PHETICE, 2008).

A model for analysing public health and health promotion competencies was developed in Work Package 4. This model, which was developed from existing international models of public health and health promotion, is designed to be flexible to allow for the broadest possible use so that it can link to other areas and can be expanded for use at European, national or local level. This model has been refined to allow for the inclusion of discipline specific, as well as core competencies.

The model is dynamic and is divided into three inter-related areas. In terms of outcome, the model is concerned with improving public health development and consists of examples of key target groups (from populations to individuals). It also allows the user to define the health model within which they work (from ICD to EUHPID). To improve public health amongst the target group, the public health process is soundly based on the core 'Health for All' values (e.g. social justice and equity) which sets the context within which the competencies are utilised and practiced. The core competencies are categorised into the following segments:

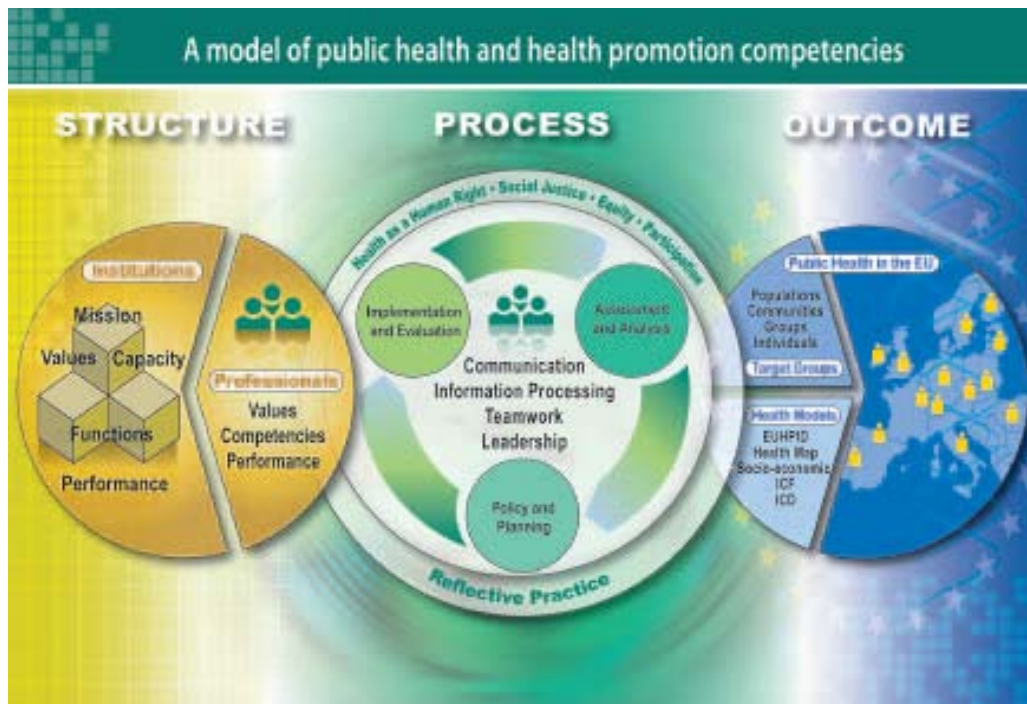
- Assessment and Analysis
- Policy and Planning
- Implementation and Evaluation
- Communication

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<sup>17</sup> [http://www.phetice.org/docs/phetice\\_guide.pdf](http://www.phetice.org/docs/phetice_guide.pdf)

- Information Processing
- Teamwork
- Leadership.

**Figure 1 - PHETICE model for analysing public health and health promotion competencies**



The cyclical process interacts with the existing structure of institutions and individual professionals and their constituent core components (e.g. missions, values, and capacities for institutions and values, competencies, and performance for individuals) <sup>18</sup>.

The PHETICE project established links with the work being conducted by ASPHER and recommended that links with other European networks be maintained (Davies et al., 2008).

#### *Association of the School of Public Health in the European Region (ASPHER)*

ASPHER was established in 1966, representing schools of public health and other public health postgraduate education and other programmes. These schools and other programmes prepare students for careers in service or academic public health including through acquisition of academic degrees in public health at all levels (bachelors, Masters and Doctorate levels. ASPHER are currently developing competence-based standards for the education of public health professionals, including those working in health promotion.

<sup>18</sup> [http://www.phetice.org/docs/phetice\\_guide.pdf](http://www.phetice.org/docs/phetice_guide.pdf)

The focus of ASPHER's European Public Health Core Competencies Programme (EPHCC) is on the development of lists of core competencies which are considered necessary for Schools of Public Health (SPHs) to train their students to be able to develop, organise, manage and forecast public health problems (ASPHER, Phase 1 report). These competencies are necessary to meet all the challenges in population health and in health systems, which a competent public health professional might expect to confront, and naturally systems for disease prevention and health promotion constitute an important component of this competencies portfolio (Birt and Foldspang, 2009).

It was decided that the competencies were more likely to be seen as appropriate and valid if they were developed in an essentially 'bottom-up' method, with the close involvement of the public health professionals who, daily, have to demonstrate public health competencies in their work. The first phase of the project involved the initial collection. All Schools of Public Health were invited to send list of competencies that they felt were important (Birt and Foldspang, 2009).

Competencies were classified within six thematic fields:

1. Methods (epidemiology, biostatistics, qualitative methods)
2. Social environment and health
3. Physical, chemical and biological environment and health
4. Health policy, organisation, management and economics
5. Health promotion and prevention
6. Cross-disciplinary themes, including strategy making, ethics, other themes.

These themes were broadly in accordance with the thematic fields supplied by the Association of Schools of Public Health (ASPH) in the United States. Each field has its own work group and sub-division of the field may be suggested by the work group chair. In order to optimise the inclusiveness of the process, if a group member suggested a competency, it was accepted for the list. The aim of this was to produce a valid picture of competencies applied in Public Health training across Europe. There was no upper limit as concerns the number of competencies (ASPHER, 2007).

Within these themes competencies were divided into two sets: practical (requiring skills) and intellectual (requiring knowledge and understanding) and each set list competencies for each of the following areas:

- Health determinants, risk factors
- Theories and principles of health promotion and prevention
- Strategy making, programme development, management and evaluation
- Communication.

Some of the competencies included in the draft practical health promotion set called for students to demonstrate the ability to describe and assess the determinants of health, describe and identify biological, physical, chemical, social and social-psychological principles and elements involved in prevention and health promotion, carry out lifestyle surveys, data analysis and qualitative research methods. The draft intellectual competencies focused on students knowing and understanding a wide range of social, psychological and economic areas including basic philosophy and



social sciences, the impact of the social environment on health, understanding the social, cultural and economic origin of the determinants of health<sup>19</sup>.

Provisional Lists of Public Health Core Competencies Phase 1 was published in October, 2007. This list was compiled from the lists of competencies received from each chair. Some competencies were edited by chairs or slightly adjusted to avoid too much repetition and overlap which will inevitably occur if mutually independent lists are just added to one another (ASPHER, 2007).

During phase 2 contacts was established with the public health stakeholders<sup>20</sup>. Two conferences were held in 2008 (Arhaus, Denmark and Paris, France) and workshops were also held in Slovenia and Scotland. Resulting from these consultations the list of competencies reported by the original six work groups were modified and the report Provisional Lists of Public Health Core Competencies Phase 2 was published in October 2008 (ASPHER, 2008). A full list of the ASPHER competencies can be found in Appendix 2.

As stated by Birt and Foldspang (2009) challenges to population health and to health systems vary over time and across European regions. It is thus hoped that this process can be continued and strengthened in Phase 3, and that it will lead to general as well as to regional agreed-upon lists of core competencies for public health education at different educational levels. Ultimately, public health competencies need to be defined so as to match appropriately differing levels of public health education and training, and also the various possible levels of public health employment (to facilitate comparability of job descriptions, genuinely free movement of public health professionals around the EU. Competencies can be monitored at the level of the individual student, and lists of competencies will also provide new potential for the development of public health degrees at the European level (Birt and Foldspang, 2009).

Phase 3 is currently underway and includes plans for Schools of Public Health and public health stakeholder interaction through conferences, local and regional workshop, classification of competencies according to training level, and continuous revision and continuous publication of revised lists of competencies.

ASPHER in their road map to 2015 are carrying out a number of Delphi Surveys to consolidate the organisations list of priorities. Both rounds of Delphi have indicated very strong support for the Competency project.

#### *IUHPE/European Initiatives*

In 2005 the IUHPE European Regional Committee formed a subcommittee with a remit to make recommendations on the development of health promotion training, accreditation and professionals standards in the European Union. A scoping study by Santa-María Morales and Barry (2007) was undertaken on behalf of the subcommittee, which explored health promotion developments across the European region.

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<sup>19</sup> <http://www.aspher.org/pliki/pdf/competenciesphase1report.pdf>

<sup>20</sup> <http://www.aspher.org/pliki/pdf/asphercompetenciesprogrammephase2report.pdf>

The aims of the scoping study were:

- To review the level of provision of specialist training in health promotion across the European regions
- To determine the current situation regarding accreditation and professional registration of health promotion workforce within countries
- To overview ongoing work at national/regional level on professional competencies and professional standards
- To determine the existence and current situation of professional pathways in health promotion within countries.

Data were received from 33 countries and the study found that health promotion training is undergoing development across Europe, albeit at different rates of progress in different countries. Only a small number of countries reported active developments on health promotion competencies and different rates of progress and development were reported. The scoping study found evidence of some development of competencies for health promotion in at least seven countries and developments in professional standards in four. Despite the small number of systems in existence, the study findings indicate that there is experience upon which to build when developing competencies and professional standards at a pan-European level (Santa-María Morales and Barry, 2007).

Based on the information acquired through the scoping study, the IUHPE/EURO subcommittee established a pilot project with participants from seven countries, to explore the feasibility of developing a pan-European competency based accreditation system. The project undertaken by Battel-Kirk and Barry (2009) identified the level of interest in, and progress towards, this development within participating countries and explored the barriers to and drivers for, competency-based accreditation. Overall, the project confirmed support for a pan-European system and recommended that such a system would need to take into account the differences between European countries in terms of their health systems, level of infrastructure and health promotion development. The participants in the project, together with eight other partners, went on to develop a successful proposal for funding to the European Commission Public Health Executive Agency (now the Executive Agency for Health and Consumers) and this is now the CompHP project. The project partners were also active in the development of the Galway Consensus Statement on domains of core competencies in health promotion (Allegrante et al., 2009), which was seen as providing a potentially useful framework for European developments.

## **INTERNATIONAL DEVELOPMENTS IN HEALTH PROMOTION COMPETENCIES**

Outside the European Union, many countries such as Australia, New Zealand and Canada have made significant progress in developing health promotion competency frameworks. A competency development framework for health education has been developed in the US. Many of these countries have also developed public health competencies that may link to and complement health promotion. While the authors acknowledge that some work in this area has also been ongoing in non-English speaking countries, this report is restricted to presenting the frameworks that have been published, or are available, in English.

### **Health Promotion Competencies in Australia**

In Australia, specialist health promotion positions were first created in the 1970s. A large number of health promotion specialists, health education teachers and other health professionals such as medical practitioners, community nurses, and allied health practitioners are involved in the delivery of health promotion throughout the country. These individuals are employed by government (Federal, State and Local), non-governmental agencies (such as National Heart Foundation, and the Cancer Foundation) and private industry. A number of University departments provide specialist training for this industry sector since 1980 (Howat et al., 2000).

The Australian Health Promotion Association is the professional association specifically for people involved in the practice, research and study of health promotion. Since its incorporation in 1990, the Health Promotion Association has grown and developed such that it now has an established function and a central place in Australia's health promotion landscape and operates at both the National and State level in order to achieve its objectives.

The health promotion workforce in Australia is drawn from a broad range of disciplines within the health sector. Membership of the Health Promotion Association is diverse and includes designated or specialist health promotion practitioners, researchers and students, as well as health professionals involved in promoting physical, mental, social, cultural and environmental health, and other generalists whose primary profession or area of study may be something different, but whose responsibilities include promoting health<sup>21</sup>.

The impetus for the development of competencies for health promotion practice came the late 1980s from the realisation that there was substantial variation among employers of the skills and competencies they required of health promotion personnel. The first national project to identify health promotion competencies in Australia was undertaken in the early 1990s. The recognition of the need to improve the credibility of the fledgling 'discipline' in Australia was one of the major objectives for the formation of the AAHPP. A research team from Curtin University and other founding members of the AAHPP instigated a process to identify relevant competencies.

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<sup>21</sup> <http://www.healthpromotion.org.au>

Development of these competencies was deemed to be an essential component in the professionalisation of health promotion in Australia (Howat et al., 2000).

A three-phase process was undertaken involving mailed questionnaires followed by workshops to develop the competencies. The Delphi process was selected to enable a relatively large sample of key stakeholders to provide their own interpretations of health promotion and its requisite skills and competences. The final phase was the application of the competencies to the development of university courses. Some 63 competencies organised into eight main categories were identified from this process:

1. Needs Assessment (carry out appropriate needs assessment)  
e.g. determine priorities for health promotion
2. Planning (plan appropriate health promotion interventions)  
e.g. develop logical, sequence health programmes
3. Implementation (implement appropriate health promotion interventions)  
e.g. produce educational packages
4. Communication (communicate effectively with other professionals and clients) e.g. apply political advocacy skills
5. Knowledge (demonstrate appropriate knowledge necessary for conducting health promotion)  
e.g. conceptualise and operationalise components of health promotion, theories of health promotion (planning, evaluation, behaviour change etc) and learning theory
6. Organisation and Management (organise and manage health promotion interventions)  
e.g. liaise and collaborate with other professionals and organisations
7. Evaluation (evaluate health promotion)  
e.g. select and apply assessment instruments
8. Use of Technology (demonstrate the application of appropriate technology)  
e.g. operate a personal computer, word processing etc (Howat et al., 2000).

These competencies were then taken and revised in 2000-01 (Shilton et al., 2005). Following a review of the literature, 45 people with substantial health promotion expertise were invited to participate. They were asked to rate the original 63 competencies based on what they considered to be:

- Essential competencies for full time health promotion professionals in any setting
- Desirable, but not essential competencies
- Specific competencies useful for specific settings or individual or
- Competencies not relevant to health promotion practice.

Respondents were also invited to suggest additional competencies and to comment. Responses were collated and competencies were amended accordingly. These revised competencies were used as the basis for round one of the Delphi study. A sample of 425 participants was identified from the mailing lists of the Australian Health Promotion Association and the Australian Public Health Association. Some 212 people responded and the responses were used to adapt the questionnaire for the second and final phase. The modified questionnaire was sent to the same sample of health promotion practitioners and a total of 207 responded. The study identified broad

consensus for a list of 83 competencies. A recommendation of the study was that the competencies should be reviewed and updated at least in a five-year cycle (Shilton et al., 2005).

These competencies were revised again in 2005 using two rounds of the Delphi method and a series of workshops in 2006 to help identify practical uses of the competencies and to determine a set of core competencies for health promotion practice in Australia. During the first phase the list of 75 competences from 2001 were reviewed and edited by the management group (five members from the organisations involved). This was followed by a consultation with a group of senior health promotion professionals from around Australia who advised on modifications to the 2001 competencies list. The competencies were sent to an expert panel of 39 participants by email as a web-based multiple-choice survey using a programme called 'Survey Monkey' (Shilton et al., 2008). The participants were requested to rate the list of competencies using the same criteria as the 2000 study. Comment was invited. Few changes were recommended and the competencies were amended accordingly. These revised competencies were then used as a basis for the main survey for health promotion practitioners.

The second phase was part of a modified Delphi study where the revised competencies list was emailed as an online questionnaire, again via Survey Monkey, to the Australian health promotion workforce, identified from memberships lists of AHPA and PHAA, and through contact with employing organisations such as non-governmental organisations (NGOs) and health departments. Participants were invited to rate each competency as 'essential', 'desirable' or 'not relevant' and to suggest changes to the wording as well as additions to the list (Shilton et al., 2008). Some 400 health promotion practitioners responded. This was followed by a series of workshops throughout Australia to identify practical uses of the competencies and to determine a set of core competencies for health promotion practice in Australia (Shilton et al., 2008).

Based on the previous research (Shilton et al., 2005, James et al., 2007, Shilton et al., 2008), the identification of core competencies for health promotion was progressed by the Australian Health Promotion Association (AHPA) in 2008. The Health Promotion Competencies project is integral to the AHPA's 2009-2012 strategic plan, which has as one of its objectives, the development of an effective and sustainable health promotion workforce in Australia. The AHPA developed a national competencies framework, which is designed to be used across all areas of health promotion and is aimed at graduate level entry. The major competencies identified as part of this framework required include:

1. Programme planning, implementation and evaluation competencies
  - 1.1 Needs for situational assessment competencies
  - 1.2 Programme planning competencies
  - 1.3 Competencies for planning evidenced-based strategies
  - 1.4 Evaluation and research competencies
2. Partnership building competencies
3. Communication and report writing competencies
4. Technology competencies

5. Knowledge competencies (please see Appendix 3 for the full list of competencies).

The framework states that there is an implied ethics behind the practice of health promotion and that it is essential that core health promotion values and principles underpin contemporary health promotion practice. A set of 12 principles (see Appendix 3) based on the American Public Health Leaderships Society's Principle of Ethical Practice of Public Health is published with the framework. These principles form the basis for the development of an ethical framework for the competencies and will be used by the AHPA as the foundation for the construction of a Code of Ethics.

Cultural competencies for health promotion have also been developed in Australia but these are not linked to the 'professional' competencies discussed above. However, it is recognised that cultural competencies are an important element to be considered when developing competencies for a multicultural global health promotion community<sup>22</sup>.

### **Health Promotion Competencies in Israel**

In Israel, career structures are reported as being unavailable for most health promoters and according to Melville et al., (2006) this results in an inadequately skilled workforce. No policy regarding the development and implementation of health promotion programmes has, it is reported, ever been finalised. There are many diverse organisations involved in health promotion in Israel, including the Israeli Ministry of Health, Education, Defence Forces, and various NGOs. Many of the doctors, nurses, and teachers etc who work in health promotion have had no formal training in this area.

The first study which attempted to define health promotion competencies for the Israeli workforce was carried out by Melville et al., (2006). This study explored the views of Israeli health promotion practitioners regarding the competencies relevant for health promotion practice in Israel. The then current Australian health promotion competencies were modified to suit Israeli requirements and several new competencies were added.

In exploring competencies in the Israeli context, a four phase method based on the Australian competency methodology was used. For the first phase a literature review was conducted. For the second phase, the questionnaire and cover letter used in the development of the Australian competencies were translated into Hebrew. One of the barriers identified at this time was that there was no agreed terminology in Hebrew for a number of the terms denoting some actions and concepts associated with health promotion practice. To deal with this, an expert panel consisting of three health promotion professionals, two higher-education professionals and a communication expert was enlisted and the questionnaire was adapted to include seven more competencies and several linguistic adaptations were made.

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<sup>22</sup> [www.ceh.org.au](http://www.ceh.org.au)

Phase 3 consisted of compiling a list of 97 health promotion professionals including those who attended National Health Promotion Conferences, the Israeli Health Promotion Association (now defunct), health promotion employees from two health service organisations and also included those working with marginalised groups and ethnic minorities.

Participants were asked to indicate whether they considered each competency to be:

- An essential core competency for full time health promotion practice in any setting
- A desirable competency, that was not essential
- A specific competency useful for specific settings or individuals hence for some, but not all, health promotion practitioner or
- Not relevant for health promotion practice.

In addition they were requested to suggest new competencies. Ninety seven questionnaires were posted with pre-paid envelopes. 72 participants responded. Respondents were advised that the returned questionnaires would remain confidential. 86% of the respondents had Masters' degrees but only 16% had completed some form of health promotion training either at a post-graduate level or at an in-service training.

Respondents were asked to rate competencies from eight categories: needs assessment, planning, implementation, communication, knowledge, organisation and management, evaluation and research, and use of technology, and indicate if they considered each competency to be essential, desirable, specific or not relevant to health promotion practice. They were also asked to provide comments on each broad category and to suggest new competencies.

The study was also unique in that it compared two geographically, linguistically, culturally and educationally distinct cadres of health promotion professionals. The opinions of the Israeli respondents varied from those of their Australian counterparts mainly on competency clusters referring to the policy role of health promotion practitioners, advocacy skills, capacity building, the need to be competent in health related screening and research and evaluation skills. The results were inconclusive but the former three may indicate that an established health promotion infrastructure enables health promotion practitioners to take on a policy role including advocacy, by providing them professional status (See Appendix 4 for the full list of Israeli competencies).

### **Health Promotion Competencies in New Zealand**

In 1983 a series of workshops on the planning and evaluation of health education and health promotion took place in New Zealand. At this time health promotion as a profession was evolving around the world from the more traditional health education practice. Over the next few years there was increased coordination between the different voluntary and government organisations and in 1986 the Health Promotion

Forum was formed<sup>23</sup>. The forum is the national umbrella organisation that provides leadership and support for good health promotion practice and is comprised of all the major government funded health promotion providers as well as a significant number of community and *iwi* organisations (McCracken et al., 2000).

The Health Promotion Forum (HPF) takes a broad approach to health promotion focusing on improving the determinants of health, and social equity. The forum provides information, training and skills development to the health promotion workforce and organises opportunities for networking, informed debated and contribution to policy development regionally, nationally and internationally. In New Zealand, health promotion is described as a discipline within public health, and “*a framework and process to improve health which can be used by communities and people throughout and beyond the health sector, and an approach to social justice and social change*”<sup>24</sup>. Health promoters in New Zealand come from a variety of settings and may not necessarily identify themselves as health promoters (McCracken et al., 2000). Most health promoters work in Maori and Pacific health services, community organisations, public health units, district health boards, primary health organisations and education services.

The call to develop competencies for training and practice in health promotion is reported as coming from diverse health promotion stakeholders. At the Health Promotion Forum conference in 1997 a proposal was raised for the establishment of a training standards board. The funding was raised for the development of core competencies and competency based standards for health promotion. A team from the Health Promotion Forum began this work in early 1998. The process focused on workforce involvement through a series of consultative discussion papers sent out to more than 1200 organisations and individuals and a ‘think tank’ to monitor feedback.

A literature review of international competency models highlighted two gaps. There was very little in the literature to do with indigenous peoples and there was an emphasis on health education rather than the wider aspects of health promotion. The next phase involved the development of a background paper on the competency debate which was the first consultation tool used in the process. This was widely distributed to 900 names and organisations taken from the Health Promotion Forum’s register and feedback was received.

Later in 1998 a ‘think tank’ consisting of 25 people was formed. The participants reflected the diversity of the workforce and special care was taken to provide for Maori input. Four drafts of the competency framework were developed and think tank members commented on each draft which was then used as a basis for the subsequent draft. During the framework’s development, some think tank members further consulted with colleagues in their workplaces. This extended group helped to ensure the realities of practice were kept in mind, thus preventing the project becoming too academic (McCracken et al., 2000).

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<sup>23</sup> [www.hpforum.org/nz/page.php?p=5&fp=2](http://www.hpforum.org/nz/page.php?p=5&fp=2)

<sup>24</sup> [www.hpforum.org/nz/page.php?28](http://www.hpforum.org/nz/page.php?28)



After the second draft, the document was again sent out to the Health Promotion Forum's mailing list to give the general health promotion workforce the opportunity to have another round of input. At this and at every other feedback it was made clear that everyone with a role in health promotion was welcome to give feedback. Articles were published in the Forum's quarterly newsletter and this helped keep the workforce up to date. The fourth draft produced the framework Health Promotion Competencies for Aotearoa-New Zealand, A Developing Framework which was distributed in April 1999. The preamble stressed that the document should be seen as a dynamic and evolving framework, able to be adapted to suit the needs of those using it (McCracken et al., 2000). The competency document describes the multi-faceted skills that the health promotion workforce needs to do their jobs well. It is designed to empower workers at all levels through a variety of possible uses including:

- Quality improvement courses
- Training courses
- Strategic development
- Staff development
- Staff recruitment and selection.

The document contains four separate but related sections which together comprise the health promotion competencies framework.

The first section is concerned with a clear commitment to integrate Maori values, culture and norms into the competencies framework and to recognise the *Treaty of Waitangi* or *Te Tiriti O Waitangi* as the basis for health promotion action in Aotearoa/New Zealand. While the majority of the population of New Zealand is of European origin, the indigenous culture is Maori. In addition significant sized populations from several Pacific Island nations and a growing migration from Asia are important elements in an increasingly multicultural mix. *Te Tiriti o Waitangi* or the *Treaty of Waitangi*, was signed in 1940 between the British crown and many of the Maori tribes, is the founding document of the nation and provides both partners, Maori (Tangata Whenua) and non-Maori (Tauwiwi) with their right to occupy the land (McCracken et al., 2000). The *Tiriti Understanding o Hauoar* in Aotearoa was published in 2002. This document aims to help people and organisations working in health promotion to further understand and apply *te Tiriti* in their everyday work and to help health promoters understand why *te Tiriti* has paramount relevance to health promotion. Becoming more competent and at ease with these matters is important for professional development and effectiveness for health promotion organisations and practitioners<sup>25</sup>.

The second section is concerned with values and ethics, which provide a means to guide and appraise health promotion conduct and practice. Health promotion core values include a belief in equity and social justice, respect for the autonomy and choice of both individuals and groups with collaborative and consultative ways of working. There is a particular emphasis on the integration of Maori customs and cultures.

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<sup>25</sup> <http://www.hpforum.org.nz/Tuha-nz.pdf>

The following statements are outlined as providing a vision of ethical practice relevant to the unique context in Aotearoa-New Zealand:

- Recognise the Maori as *tangata whenua* ('people of the land') and acknowledge the provisions of *te Tiriti O Waitangi*
- See Aotearoa-New Zealand as a country in which Maori have at least the same status as non-Maori
- Have health promotion actions and outcomes that reflect the hopes and aspirations of Maori for self determination in respect of their own affairs
- See informed individuals, *whanāu* (or extended family networks) and communities empowered to make their own choices and realise their full potential through utilising community development principles
- Be based on effective healthy public policies, supportive social, cultural and physical environments, the development of personal skills and a health system focused on wellbeing
- Have a well resourced and competent workforce
- Work towards achieving social justice and equity through strong commitment to the prerequisites and determinants of health.

The third section is concerned with performance criteria which identify a number of elements for each of seven knowledge based competency clusters and nine skills based competency clusters. Elements describe the knowledge or activities expected in the cluster. Performance criteria describe the behaviour that constitutes competency. It is likely that practitioners will be working at different levels within knowledge and skill areas at the same time. The performance criteria are divided into three performance levels denoting the different levels of competence. At each performance level there is recognition for learning gained through training and on the job experience. Health promoters will take varying years of experience before they perform at the different levels. While presented as discrete entities these levels are best thought of as inter-related and continuous and most practitioners will overlap on more than one level.

**Table 1 - Performance Levels in the Health Promotion Competencies  
for Aotearoa-New Zealand**

	Level One Approximately up to two years	Level Two Approximately two- five years	Level Three Approximately More than five years
Practitioner Experience	<ul style="list-style-type: none"> <li>▪ Developing health promotion knowledge and skills</li> <li>▪ Undertaking health promotion work but requiring supervision of day to day work</li> <li>▪ participating in team meetings and networking</li> </ul>	<ul style="list-style-type: none"> <li>▪ applying sound health promotion principles</li> <li>▪ accessing supervision in challenging work contexts</li> <li>▪ taking a leadership role in team</li> </ul>	<ul style="list-style-type: none"> <li>▪ Advancing health promotion practice as a skilled practitioner</li> <li>▪ working unsupervised in most work contexts and environments</li> <li>▪ critically reflecting on practice</li> <li>▪ acting as a catalyst in teams</li> </ul>
Qualifications and training	<ul style="list-style-type: none"> <li>▪ evidence of formal or informal learning of health promotion principles and practices</li> <li>▪ Attending appropriate workshop opportunities</li> <li>▪ receiving workplace mentoring supervision</li> </ul>	<ul style="list-style-type: none"> <li>▪ likely to be working towards a recognised qualification in health promotion or related area</li> <li>▪ recognising individual training needs and actively seeking further upskilling</li> <li>▪ utilising and participating in peer learning opportunities</li> </ul>	<ul style="list-style-type: none"> <li>▪ Evidence of a recognised qualification in health promotion or related area</li> <li>▪ actively pursuing ongoing formal or informal learning</li> <li>▪ assisting the learning of others</li> <li>▪ providing supervision and mentoring to others</li> </ul>

The New Zealand competency framework is a culturally sensitive framework that identifies elements for each of the seven knowledge-based and nine skill-based competency clusters. The knowledge based competencies reflect learning from a variety of sources, including a range of social and behavioural science, while also recognising the learning accumulated by experienced health promoters in the field. The skills based competencies reflect ability acquired from a variety of sources. These include skills which have been learnt as a result of formal training, as well as those developed on the job. See Appendix 5 for the full list of competencies.

A review of the competencies was carried out and the report was published in 2004. The review also included assessing requirements for developing the health promotion

competencies into national standards and possible pathways for that to occur if consultation confirmed such a need (Health Promotion Forum of New Zealand, 2004).

The review found that the competencies were used in different ways including, for staff development, strategic development, training, quality assurance, programme development, staff recruitment and development. However, some concerns raised related to lack of use and the need for support for health promotion especially by management. The values and ethics section was considered to provide underpinning principles for health promotion practice and has been used for drawing up job descriptions, developing service codes of ethics, resource allocation and discussion on service plans. Generally, the feedback suggested that the health promotion competencies were seen to provide concrete evidence of the substance and breadth of health promotion. They were viewed as being a useful and informative tool and were rated highly as a good benchmark of the knowledge and skills required in health promotion.

Among the 17 recommendations made in the report were the following:

- That a comprehensive strategic and action plan to strengthen the development of health promotion knowledge, skills and practice be developed in conjunction with other workforce development initiatives in public health
- Consultation should be undertaken with Maori health promotion practitioners and the competencies revised depending on the outcome of these consultations. This is likely to include a section relevant for Maori health promotion workers
- A comprehensive survey be undertaken to identify and define the health promotion workforce including educational qualifications, relevant experience, career plans, and structures, pay scales. Such a survey could provide a framework to start identifying the workforce
- That a working party be established to consult on and develop health promotion standards to support the development of minimum nationally consistent benchmarks for health promotion practice. Use of the standards initially will be voluntary
- That organisational competence in health promotion delivery be encouraged through the use of accreditation processes (Health Promotion Forum of New Zealand, 2004).

#### *Public Health Competencies in New Zealand*

In 2003, the Ministry of Health commenced work led by the Public Health Association to lead and participate in the development of the public health workforce and to strengthen public health job skills in the wider health workforce. The objective of the Public Health Workforce Development Project (PHWDP) was to develop a national approach to public health workforce development in New Zealand. Various workforce surveys and a series of consultations began in 2003 and ran through to 2005 (Rance, 2007). In 2004, a coalition of public health disciplines, including health promotion, began work on a set of generic competencies for public health practitioners. This project was part of the wider PHWDP (Rance and Sewell, 2007).

A discussion document on Draft Generic Competencies for Public Health Practitioners in Aotearoa-New Zealand was circulated for consultation in 2006. Views were collated and meeting were held as part of the consultation process and the Generic Competencies for Public Health in Aotearoa-New Zealand was published in 2007. It states that many disciplines, for example health promotion and public health medicine, have existing competency sets, other disciplines are in the process of developing their own discipline/specific competency sets and professional competencies will continue to be benchmarked within these disciplines. However, given the overlap at the baseline level, the document indicates that discipline-specific competencies will need to align with the generic competencies to ensure consistency.

The Generic Competencies for Public Health (Public Health Association of New Zealand, 2007) provide a minimum baseline set of competencies that is common to all public health roles across all public health sectors. The health promotion competencies sit on this baseline. Generic competencies prescribe the knowledge, skills and attitudes required for all public health practice at the baseline level. For example, basic knowledge of regulatory tools is not part of the health promotion competencies, nor is knowledge of health economics part of the public health nurse competencies. But the inclusion of these areas in a set of generic competencies across public health will mean all practitioners will share the essential baseline competencies common to all fields and disciplines of public health.

Discipline-specific competencies consist of higher-level knowledge, skills and attitudes that include and extend the baseline for those competencies that are part of the discipline's specialist field. These competencies can be described as being at Advanced and Expert Levels. There are also many discipline specific competencies that are outside the scope of the generic competencies. These include some cultural competencies that are specific to particular contexts.

The intention of the generic competencies is to provide a clearly articulated set of competencies that is accepted by the sector as the minimum level of ability needed in each area of public health. Advanced and expert practitioners will have extensive competence in their own fields, but may need only baseline competence in other fields and disciplines. There are 12 topic areas and each topic comprises a set of competency statements. The topics are further divided into two broad sub-sets: Public Health Knowledge and Public Health Practice Public Health Association of New Zealand, (2007). See Appendix 5 for the complete competency framework.

The relationship between these baseline set of generic competencies for public health and the development of the more specific health promotion competencies developed by the Health Promotion Forum, as described above, remain unclear. Clearly, some alignment of the baseline competencies with those already identified for health promotion practice is needed in order to advance a coherent national framework.

## Health Promotion Competencies in Canada

The emergence of health promotion as a distinct field of practice in Canada, on foot of the publication of the Ottawa Charter (WHO, 1986), gave rise to discussions about the need for skills-based competencies defining the scope of health promotion practice. For the first time, public health and social service organisations in Canada created positions with 'health promotion' embedded in the job title (Hyndman, 2009). A key aspect of this debate concerned the development of health promotion competencies, a skills-based set of criteria that those working in the field of health promotion, should, at least in part, be expected to meet (Hyndman, 2007).

Sporadic debates about the benefits and risks of health promotion competencies occurred during the 1980s and 1990s. The issue of health promotion competencies was first explored in 2000 at a symposium organised by the Canadian Association of Teachers in Community Health (CATCH). The group concluded that competencies could be useful if they were broadly defined and thought of as guidelines but they could be limiting if they were narrowly defined or adhered to rigidly (Hills and O'Neill, 2003) as this could prove detrimental to a field that was still evolving (Hyndman, 2009).

Subsequent developments were set in motion by two key factors. Firstly, there was growing concerns about the potential marginalisation of health promotion within the broader public health sector. These concerns were expressed after a series of consultations with practitioners in Ontario. Secondly, there was an increasing recognition of the need to take a competency-based approach to public health workforce development in Canada. This was a common message from a series of stakeholder regional workshops on public health education that were held in early 2004 and was also re-iterated in a review of international best practices for public health workforce development (Moloughney, 2006). A national public health renewal process which included the creation of the Public Health Agency of Canada (PHAC) in 2004, launched a competency based approach to public health workforce development. A federal Public Health Human Resources Joint Task Group commissioned the development of set of public health competencies in 2004 and a draft pan-Canadian human resource development framework was released in 2005. The latter document highlighted the importance of core competencies for the entire public health workforce, as well as the importance of indentifying competencies for discipline groups (Moloughney, 2006; Hyndman, 2007).

In 2005 the Public Health Agency of Canada released a set of 62 core competencies that would undergo a pan-Canadian consultation process. The set of core competency statements in Core Competencies for Public Health in Canada Release 1.0<sup>26</sup> which was published in 2007, describe a competent provider, and are the result of an extensive consultation carried out with over 3000 public health practitioners, and representatives of organisations and all levels of government. It is expected that new public health professionals will be properly prepared at a baseline level and will be ready to build on these understandings and skills with practice. The publication of this

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<sup>26</sup> <http://www.phac-aspc.gc.ca/ccph-cesp/pdfs/cc-manual-eng090407.pdf>

document was a catalyst for other public health disciplines to define their own set of discipline-specific competencies. See Appendix 6 for the full list of competencies.

Health promoters working in the field of public health recognised that they risked further marginalisation if they failed to play a lead role in developing a set of competencies that incorporated the key concepts, values and principles underlying health promotion practice (Hyndman, 2009).

In 2005 Health Promotion Ontario (HPO) undertook a review of existing health promotion competencies. Several examples were considered, including competencies developed for health promoters in Australia and New Zealand and an academic set of competencies developed by the MHSc degree programme in health promotion at the University of Toronto<sup>27</sup>, as well as over 60 current job descriptions for health promoters that were in use at Ontario public health units. From this, a discussion paper, which included a draft set of discipline-specific competencies, was published (Hyndman, 2007). The draft set of competencies consisted of eight primary statements or domains and each primary statement contained a number of secondary statements. The primary statements and selected examples of the secondary statements include the following:

1. Demonstrate knowledge necessary for conducting health promotion that includes:
  - 1.2 Applying theory to health promotion planning and implementation
2. Conduct a community needs/situational assessment for a specific issue that includes:
  - 2.3 Identifying community assets and resources
3. Plan appropriate health promotion programmes that include:
  - 3.4 Monitoring and evaluating implementation of interventions
4. Contribute to policy development that includes:
  - 4.3 Providing strategic policy advice on health promotion issues
5. Facilitate community mobilisations and build community capacity around shared health promotion that include:
  - 5.3 Advocating for and with individuals and communities that will improve their health and wellbeing
6. Engage in partnership and collaboration that include:
  - 6.3 Building coalitions and stimulating intersectoral collaboration on health issues
7. Communicate effectively with community members and other professionals that includes:
  - 7.1 Providing health status, demographic, statistical, programmatic, and scientific information tailored to professional and lay audiences
8. Organise, implement and manage health promotion Interventions that include:
  - 8.3 Contributing to team and organisational learning.

An online survey was developed to collect feedback from the practice communities on the appropriateness and validity of the proposed competency statements. This survey

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<sup>27</sup> [http://www.phs.utoronto.ca/mhsc\\_health\\_promotion4.asp](http://www.phs.utoronto.ca/mhsc_health_promotion4.asp)

presented all the secondary competency statements within each primary statement or domain and for each competency it asked questions including the following:

1. Does this reflect your role as a health promotion practitioner?
2. Should this be a competency for all Promotion Practitioners?
3. Comments.

As a result of the consultation a new revised draft was developed. Key points of feedback included:

- Expand on evaluation competencies, highlight evaluation skills, or have separate competencies
- Develop companion/guidance documents addressing theories, best practices, guiding principles and ethics
- Include advocacy - an explicit description is needed to reflect a health promoters' role in advocacy, both internal and external - consider having advocacy as a stand-alone competency
- Budgeting is often a managerial responsibility but an asset to have as a health promoter
- Broaden the competencies to be inclusive of non-public health/health promoters (working in community health centres, non-governmental organisations (NGOs) and hospitals)
- Continue to reflect cultural competencies, diversity, inequities/disparities
- Remove 'coordinating volunteers' as this competency does not adequately reflect scope of practice
- Use term 'faith organisations' instead of 'churches' (Ghassemi 2009). See Appendix 6 for the full list of competencies.

According to Hyndman (2009) an overarching feature of these competencies is the capacity to define, analyse and take action on health issues from a health promotion perspective. Specifically, health promoters should be able to assess the nature of the health issue or problem and provide analysis and advice on how to address it through the appropriate mix of health promotion strategies, including community mobilisation, health education, advocacy, policy development and organisational change. This skill set constitutes the 'value added' that health promoters bring to the field of public health.

One key area of debate, both in Canada and internationally concerns the extent to which standards and quality assurance mechanisms are required to assess proficiency in the domains of core health promotion competencies. The Canadian position is cautious on this issue and in 2006 it was concluded that the process required for health promotion to become a formally accredited and regulated profession would be rigorous, time/consuming and potentially divisive. In view of this, the Canadian competencies are not being seen as a step toward the mandatory accreditation but rather to inform and stimulate dialogue on the skill set required for health promotion. More detailed discussion of this point will be returned to later in this document.

## **Health Education Competencies in the US**



In the US health education is a valued public health discipline. According to the U.S Department of Labor (2008), approximately 62,000 workers self-identified as being employed as health educators in 2006. In the US this discipline has defined domains, competencies, evolved professional preparation programmes, organised professional organisations and journals, and established a body of theory and research that the fields practitioners have generated over the past six decades (Howze, et al., 2009). At the state and federal levels both the education and health departments have various roles in the administration and official jurisdiction of health education programmes and practitioners and this has led to multiple processes and agencies working on both professional preparation programme accreditation and individual practitioner certification (Speller et al., 2009).

A variety of processes currently exist that provide direction for the preparation and practice of health education in the United States. These include both individual certification and accreditation of professional preparation programmes at the university level for health education practitioners. Although they have some variation as their application has developed through the past two decades, they all have as their basis a 1978-80 role delineation/job analysis of health education (Speller et al., 2009).

The history of health education in the United States dates back to the late 19<sup>th</sup> century with the establishment of the first academic programmes preparing school health educators. Interest in quality assurance and the development of standards for professional preparation of health educators emerged in the 1940s when the American Public Health Association (APHA) began accrediting schools of public health (Allegrante et al., 2004).

The Statement of Functions of Community Health Educators and Minimum Requirements for their Professional Preparation, with Recommendations for Implementation, was published by the Society for Public Health Education (SOPHE) in 1967 and provided guidelines to universities and community employers on the role of community health educators and their preparation. In the US there are 250 academic programmes in colleges and universities preparing health educators at the undergraduate and graduate level leading to baccalaureate, master's and doctoral degrees. The American Public Health Association (APHA) Committee on Professional Education published the first criteria and guidelines for accrediting graduate programmes in community health education in 1969 (Allegrante et al., 2004). The first programmes were accredited under this process and health education was the first public health discipline to receive this designation (Howze et al., 2009).

Beginning in the mid 1970s, due to long-standing questions about what health educators do in practice, the profession began the process of developing the steps necessary to establish the credentialing of health educators. In 1978, the Workshop on Commonalities and Differences on the Preparation and Practice of Community, Patient and School Health Educators was conducted, which initiated a process for consensus building of data collection and discussions. The goal was to clarify the role of health educators and to establish standards of professional practice. This led to the agreement on the responsibilities and competencies of health educators. The 1978 Workshop on Commonalities and Differences recommended the formation of a

planning committee, which became the National Task Force on the Preparation and Practice of Health Educators (NTFPPHE). The Task Force was charged with the responsibility of developing guidelines for professional preparation that would apply in all health education settings. This group formulated and enacted the Role Delineation Study<sup>28</sup>. After extensive public discussion and background research, the initial role specification for the entry-level health education specialist was defined. The responsibilities, functions, skills and knowledge expected of the entry-level practitioners were delineated, after which a national survey of practicing health educators was conducted to verify and refine the definition. The research found that there was a generic role for all health educators. By this it meant that there are commonalities in the roles of entry-level educators regardless of the setting (e.g. community, schools etc) whether they are employed (NCHEC, 2006). A framework comprising seven areas of responsibility, 27 competencies and 79 subcompetencies was published as A Framework for the Development of Competency-based Curricula for Entry-level Health Educators (1985). This document provided professional preparation courses with a frame of reference for developing their health education curricula (AAHE, NCHEC, and SOPHE, 2006).

The NTFPPHE became the National Commission for Health Education Credentialing (NCHEC) in 1988 and was established as an independent, not-for-profit agency to administer a voluntary national credentialing system. The mission of the NCHEC is to improve the practice of health education and serve the public and profession of health education by promoting professional development, strengthening professional preparation and practice, and certifying health education specialists. The NCHEC administers a national competency-based examination, which certifies individuals at entry level who pass the examination, and administers a national system for the continuing professional development of those certified. The first national, voluntary, competency-based Certified Health Education Specialist (CHES) exam was held in 1990. More than 12,000 professionals have received the designation Certified Health Educations Specialist (CHES) nationwide<sup>29</sup>. Maintenance of certification also requires continuing education/ professional development and a recertification procedure every five years (Speller et al., 2009).

In 1992, a Joint Committee for Graduate Standards was established by the American Association for Health Education (AAHE) and the Society for Public Health Education (SOPHE) to develop graduated competencies. Postal questionnaires were sent to practitioners and institutions with graduate-level professional preparation programmes in health education and the findings identified three new areas of responsibility, together with new competencies and subcompetencies (AAHE, NCHEC, and SOPHE, 1999).

In November, 1999 a profession wide code of ethics was unanimously approved and ratified and disseminated by the leading health education professional associations and has since been used as the standard for practicing health educators. (CNHEO, 1999). See Appendix 7 for the Code of Ethics.

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<sup>28</sup> <http://www.nchec.org/aboutnchec/history/>

<sup>29</sup> <http://www.nchec.org/aboutnchec>

A new research initiative, the National Health Educator Competencies Update Project (CUP) was designed in 1998, to re-verify the role of entry-level health educators and further define and verify the role of advance-level health educators. The project was guided by the CUP 24 member National Advisory Committee (CUPAC), that included representatives from 12 national professional groups with interests in health education. The CUP built on previous work to define professional practice and contribute to the professionalisation of health education. The American Association for Health Education (AAHE), National Commission for Health Education Credentialing (NCHEC) and the Society for Public Health Education (SOPHE) jointly own the results of the research on behalf of the health education profession (Gilmore et al., 2005, 2007).

The CUP research was guided by four overarching research questions:

1. What is the current generic role of the entry-level health education specialist as compared to the role previously defined?
2. What are the generic areas of responsibility, competencies and subcompetencies of advance level health education specialists?
3. Are there commonalities in the roles of entry-level and advanced health education specialists across practice settings?
4. Are there differences in the roles of entry and advanced level health education specialists based on degrees held and years of work experience in health education? (Gilmore et al., 2005).

The study was designed to determine what health educators did at the time of the study, not what they thought they should be doing in the future. The research was conducted in several phases starting with the planning phase (1998-1999) where advisory committee members focused on levels of practice, proposed new competencies, and resource development. During 2000-2001 a national pilot study was completed with 1,600 individuals in four states to assess the clarity, completeness, and the most desirable mode of data collection for the proposed survey instrument. Based on the results of the pilot a 19 page questionnaire was produced.

The major research phase took place during 2001-2004. The 19 page questionnaire was divided into three sections:

- Part A. Analysis of Activities: contained 180 items that participants rated, on a 4-point scale, how frequently they performed each skill and how important each skill was to carrying out the responsibilities of their current position
- Part B Assessment of Responsibilities: contained items asking participants to approximate the percentage of time they spent carrying out each of 10 areas of responsibility and how important each of the 10 areas of responsibility was to their current job. They were also asked to rate, on a 3-point scale, under what conditions they were supervised as health educators or the conditions under which they supervised other health educators
- Part C Demographic Data: included items covering the participant's professional identity, present position, educational background, years of experience as a health educator, and type of organisation where the respondent was presently employed.

Questionnaires were sent through the post to a representative sample of members of national professional organisations across the US. In addition, in 16 randomly selected states, questionnaires were mailed to a random sample of individuals on lists solicited from state departments of education and public health, state affiliates of national health education organisations, allied health and medical care organisations. The two step process contributed to the representativeness the sample by providing access to health educators in the major work settings, individuals who did not belong to national professionals associations and those working at local levels (AAHE, NCHEC, and SOPHE., 2006).

Frequency and importance ratings for each item were combined into a single score. Following a review of the combined data score, 17 items were removed from further analysis because both the frequency and importance ratings were extremely low. The CUP Analysis Group (CUPAG) identified an advance analysis process named Facets for appropriately converting ordinal data into interval data enabling parametric analyses to be use. The Facets process estimates a linear measure, or logit, for each fact in the data. For this research, respondents and items were the two facets. And the resulting logit scores were transformed to a scale ranging from 0 to 100 for ease of data assessment. The Facets process addresses any instrument design and analysis flaw though the use of rating scale measurement models prior to using standard parametric analysis.

Over several months a series of emerging models of health educator roles were developed. The analytic process included both iterative statistical analyses and reviews incorporating professional judgement and re-examination of the data. Competency and subcompetency alignment was determined on the basis of preliminary and confirmatory factor analyses, subcompetency alignment with the levels of practice was determined by ANOVA analyses, preliminary and confirmatory factor analyses and these were all confirmed by the CUPAC.

What emerged was a hierarchical model (see Table 2) rather than a linear model, that characterised the previous entry-level and advanced-level models. All health educators reported performing the 163 subcompetencies identified through the research and these subcompetencies were viewed as having importance for their current job. The placement of the subcompetency into a level of practice was based on the combined score of frequency and importance considering years of experience and highest academic degree held. Those practising at the A2 level would include those competencies and subcompetencies at both the A1 and entry levels. Similarly, those practicing at the A1 level would include not only the A1 competencies and subcompetencies but also those competencies and subcompetencies at the entry level. This model is used as the basis for current professional preparation, credentialing and professional development of health educators in all practice settings in the Unite States (AAHE, NCHEC, and SOPHE., 2006; Gilmore 2007).

**Table 2 - CUP Model Hierarchical Approach (Gilmore, 2005)**

Level of Practice	Competencies/Subcompetencies
Entry (less than 5 years of experience, Baccalaureate or master's degrees)	Entry
Advanced 1 (5 or more years of experience, baccalaureate or master's degree)	Entry + Advanced 1
Advanced 2 (doctorate and 5 or more years of experience)	Entry + Advanced 1 + Advanced 2

The CHES exam was updated in 2007 to align it with the findings of the CUP. Because the CUP results demonstrated health education practicing at advanced levels the NCHEC is currently in the process of instituting an advanced-level certification (Speller et al., 2009).

The NCHEC are currently conducting, with the assistance of the Professional Examination Service (PES), a Health Educator Job Analysis. The purpose of the analysis is to validate the contemporary practice of entry-level and experienced health educators. Since 2008, PES representatives and the steering committee have been working with 65 volunteer health educators to develop a survey instrument for use in the job analysis. The instrument was designed to obtain feedback from health educators about practices in their work settings. Structured interviews, focus groups, and a modified Delphi technique were used in various stages of the process. Sources that served as the basis for instrument development included:

- The Competency Update Project (CUP) Model
- Recommendations from the Coalition of National Health Education Organisations (based on a study of health educator hiring practices and a 'crosswalk analysis' of health education and public health competencies)
- Galway Consensus Statement
- Definitions of health education terminology established by the Joint Terminology Committee.

Analysis results will be used to validate and update, as need, the areas of responsibility, competencies, and subcompetencies of the health education profession (The CHES Bulletin, Fall 2009).

#### *Core Competencies for Public Health Professionals*

Alongside the development of a comprehensive set of competencies for health education, there have also been some developments in the US on core competencies for public health professionals. Two specific initiatives, by way of example, will be covered here.

In 2004 the Association of Schools of Public Health (ASPH) initiated the development of a Core Competency Model for the Masters in Public Health (MPH).

The discipline-specific competency domains that had generally been accepted since the 1970s included:

- Biostatistics e.g. interpret of results of statistical analysis
- Environmental health sciences e.g. discuss various risk management and risk communication approaches in relation to issues of environmental justice and equity
- Epidemiology e.g. apply the basic terminology and definitions of epidemiology
- Health policy and management e.g. demonstrate leadership skills for building partnerships
- Social and behavioural sciences e.g. identify the causes of social and behavioural factors that affect health of individuals and populations.

The ASPH competency model initiative extended the competency domains and included the following interdisciplinary and cross-cutting domains:

- Communication and Informatics e.g. demonstrate effective written and oral skills for communicating with different audiences in the context of professional public health activities
- Diversity and Culture e.g. apply the principles of community-based participatory research to improve health in diverse populations
- Leadership e.g. use collaborative methods for achieving organisational and community health goals
- Professionalism e.g. analyse determinants of health and disease using an ecological framework
- Program Planning e.g. describe how social, behavioural, environmental, and biological factors contribute to specific individual and community health outcomes
- Systems Thinking e.g. explain how the contexts of gender, race, poverty, history, migration, and culture are important in the design of interventions within public health systems.

These competencies are not designed to serve as a framework for required courses but they are aimed at providing a baseline overview of the knowledge, skills, and other attributes expected of emerging public health professionals.

The public health foundation in the US have also developed core competencies for public health professionals. These are a set of skills desirable for the broad practice of public health. They reflect the characteristics that the staff of public health organisations (collectively) may want to possess as they work to protect and promote health in the community. These competencies are designed to serve as a starting point for academic and practice organisations to understand, assess, and meet training and workforce needs<sup>30</sup>.

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<sup>30</sup> <http://www.phf.org/link/corecompetencies.htm>

## **Developments in Other Countries**

Almost all of the countries in the African region have structures for health education and/or health promotion and there are numerous legislative frameworks that support the development of core competency and credentialing of health promotion and health education in most African countries. Some countries such as South Africa, Botswana and Nigeria have policies that support health education and health promotion development. One of the thrusts in the recently published health promotion policy in Nigeria, is capacity building at all levels. In Botswana the national policy makes provision for the development of professional health education and health promotion officers (Onya, 2009). In South Africa a Health Promotion Partnership Project was launched in 1998. The partnership consisted of the health promotion units of three universities in addition to the health services at local, regional and national levels. The mission was to develop and enhance existing courses, standardise training, build capacity etc. The Standards Generating Board (SBG) was formed with the aim of focusing on the development of standards and qualifications. However, this development was thwarted and was overtaken by initiatives of the Public Health Association of South Africa. In a 2003 paper by Nyamwaya it is suggested that there is only limited cooperation among players in health promotion in Africa and that there is a need to elaborate the theoretical bases of health promotion, to lay structured plans for professionalisation of practitioners and to call for action on the issue (Onya, 2009).

In terms of Japan, the competencies development process has related mainly to the practice of health education. Japan initially followed the CHES system in the US and has recently developed a credentialing system for Japanese health educators. The need for health educators was first discussed in 1994, and more detailed discussions of the development process began in 1998 by the Japanese Society of Health Education (HSHE). At the end of 2002, the credentialing of Japanese health educators was approved by the Japanese government as a Non-Profit Organisation (NPO). The NPO distinguishes between practical health educators and health education specialists, who have more advanced skills on health education and promotion. As yet the NPO have not decided on the specific responsibilities and competencies for the practice health educators as well as health education specialists in Japan. A study carried out by Sagakami (2006) assessed the coverage of the CHES responsibilities and competencies in the Japanese health education system and concluded that not all CHES competencies developed in the US were covered to the same degree by parallel health education-related programmes currently offered in Japan. Sagakami (2006) also concluded that some of the CHES competencies developed in the US may not be adequate for future Japanese health educators.

In the Latin American region, the Inter-American Coalition of Universities and Training Centres for Health Education and Health Promotion Personnel has been studying the different foci, competencies and characteristics of health promotion and health education professional training programmes. The Coalition, along with other Latin American entities, has reiterated the challenges in the field of health promotion and health education, and the need for professional training in the region. These include maintaining an active forum to constantly refine professional competencies (Arroyo,

2009). As an example of a country specific initiative, in Peru an intervention was developed between 2002 and 2005 to develop capacity in health promotion. The underlying premise was that strengthening the health promotion competencies of professionals and institutions would support the improvement of health behaviours and conditions in the country. Although the intervention was not formally evaluated it was still possible to draw some lessons from the intervention. Among the key lessons identified were that: successful capacity development requires the strengthening of institutional networks; training activities alone are insufficient; educational opportunities need to be integrated into strategies that aim to institutionalise competencies in specific work contexts and promote the inter-institutional linkages. The experience also suggested that capacity development programmes need to start by assessing challenges to make competencies effective in job performance (Waisbord, 2006).

There are a number of developments in many other countries about which details in English could not be included for the purpose of this review. However, suffice to say that the field of professional competencies for health promotion practice is something that is clearly of interest globally with variation between countries regarding the levels of development in identifying and agreeing competencies. However, there is clearly a growing awareness and understanding of the importance of advancing these developments globally. In this context, the focus of the Galway Consensus Statement published in 2009 to promote dialogue and exchange of understanding among international actors in this field marks an important step in moving towards some consensus regarding the domains of core competency that should guide the professional preparation and practice of health promotion.

### **The Galway Consensus Conference Statement**

Building on international developments, the 2008 Galway Consensus Conference was seen as a first step in moving towards international accord on the core competencies necessary for the professional preparation of health promotion and health education specialists. This conference sought to promote exchange and greater collaboration on the development of core competencies in health promotion and the strengthening of common approaches to capacity building and workforce development. The IUHPE in collaboration with the Society for Public Health (SOPHE), the US Centers for Disease Prevention and Control, and other partners convened at the National University of Ireland, Galway on June 16-18, 2008, for the Galway Consensus Conference, which resulted in the publication of the Galway Consensus Statement on the Domains of Core Competency for Health Promotion and Health Education (Allegrante et al., 2009; Barry et al., 2009). The conference participants came from institutions of higher education and from key governmental entities, non-governmental organisations, and professional societies at the national and global levels. The conference sought to engage the participation of leaders and stakeholders from throughout the world; however, of the approximately 35 leading experts who were invited to participate, 26 individuals, largely from Europe and North America, accepted the invitation and attended the conference. Several regions of the world, including the Sub-Saharan African, Asian-Pacific, and Latin-American regions, either could not be represented or



were underrepresented due to the lack of available financial resources to support travel.

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. The papers also informed the writing of a draft consensus statement that was ratified by the participants on the closing day of the conference.

The Galway Conference participants reached agreement on core values and principles, a common definition, and eight domains of core competency required to engage in effective health promotion practice. The consensus statement issued by the organisers is not concerned with specific competencies, but, rather, distinctly focused on the broader domains of core competency, which are critical to achieving improvements in health. The eight domains of core competency are outlined as follows:

1. Catalyzing change – enabling change and empowering individuals and communities to improve their health
2. Leadership – providing strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion, and building capacity
3. Assessment – conducting assessment of needs and assets in communities and systems that leads to the identification and analysis of the behavioural, cultural, social, environmental, and organisational determinants that promote or compromise health
4. Planning – Developing measurable goals and objectives in response to assessment of needs and assets and identifying strategies that are based on knowledge derived from theory, evidence, and practice
5. Implementation – Carrying out effective and efficient, culturally sensitive, and ethical strategies to ensure the greatest possible improvements in health, including management of human and material resources
6. Evaluation – determining the reach, effectiveness, and impact of health promotion programmes and policies. This includes utilising appropriate evaluation and research methods to support programme improvements, sustainability, and dissemination
7. Advocacy – advocating with and on behalf of individuals and communities to improve their health and well-being and building their capacity for undertaking actions that can both improve health and strengthen community assets
8. Partnerships – working collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion programmes and policies.

The Galway Consensus Statement is intended for several audiences, including: practitioners, researchers, and academics in health promotion and health education; policy and decision-makers in government and non-governmental entities; employers; and international organisations and other institutional authorities, who have a stake and a responsibility in promoting the health of the public. The Consensus Statement

also identified several recommendations and key actions that would be necessary to strengthen and secure a global commitment to improving health promotion practice by further advancing the field and providing direction for enhancing the academic preparation of health promotion practitioners. One of these was to convene groups of professionals at the regional levels to discuss the Galway Consensus Statement and its implications for informing future workforce capacity-building efforts.

The Consensus Statement in draft form was circulated for feedback to 216 health promotion experts from around the world, sourced from the IUHPE membership database and WHO Regional Offices. In addition, the IUHPE's online dialogue forum, Views of Health Promotion Online<sup>31</sup>, and SOPHE's online discussion site<sup>32</sup> started a stream for members and non-members to openly comment on any and all aspects of the draft. Comments, suggestions, and recommendations were then collected during a six-month period from July 1, 2008 to January 31, 2009. Feedback was requested on the following issues:

1. Are there domains other than the eight that should be considered or added?
2. Are there domains that should be deleted?
3. Are there domains that could be clarified by specific wording changes?
4. Are there places in the world of health promotion where part or all of the statement would not be relevant or appropriate?

The main points of feedback from this exercise may be summarised as follows:

- Include Communication as a core competency
- Consider separating the domains to represent knowledge and skills for programmatic (assessment, planning, implementation and evaluation) and policy areas (advocacy, partnership etc)
- Greater focus on addressing inequity
- Include catalysts for change at organisational levels – governments etc
- Include leadership, management and infrastructure under capacity building
- Clarify and distinguish between health promotion and public health and between health promotion and health education
- Lack of representation from southern hemisphere in drafting the document was commented on.

In 2009 the Galway Consensus Statement, along with eight commissioned background papers and five sets of comments and commentaries from the field, was published in tandem issues of the IUHPE journal, Global Health Promotion (Vol. 16, No. 2, June, 2009) and SOPHE's journal Health Education and Behavior (Vol. 36, No.3, June 2009). While HEB focused on professional competencies and accreditation developments in North America, particularly the United States; GHP incorporated a number of international perspectives from Africa, Australia, Canada and Latin America. Both GHP<sup>33</sup> and HEB<sup>34</sup> issues are available open access on their respective websites in SAGE's online platform until the IUHPE World Conference in July 2010.

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<sup>31</sup> <http://www.vhpo.net>

<sup>32</sup> [www.sophe.org](http://www.sophe.org)

<sup>33</sup> <http://ghp.sagepub.com>

<sup>34</sup> <http://heb.sagepub.com>

Following the publication, a further global consultation process was undertaken in collaboration with the IUHPE Regional Vice Presidents. The six IUHPE Regional Vice Presidents were contacted and requested to engage in regional consultation concerning feedback on the domains identified in the Galway Consensus Statement and the likely impact of the Statement on health promotion practice, education and workforce development in their region. In general, the initiative was welcomed and was viewed as being supportive of local/national developments. The main issues raised by way of feedback included:

- Domains are too broad, too vague- not specific enough to health promotion
- Keep flexibility within the domains
- Difficulties in implementing / getting acceptance for domains – need for cultural appropriateness/adaptation
- Need for more 'core values/ethical' elements, connect the domains to the principles of practice
- Need for greater recognition of partnership with communities, capacity building, social capital, inequity, social change, participation, organisational and systems change, social justice and human rights
- Questions about entry skills/knowledge levels in relation to domains and how/who would assess
- Perceived duplication, presence of other frameworks in certain countries
- Don't make it exclusionary – continuous development process rather than rigid standards.

A more detailed analysis of feedback responses is being conducted and will be reported in a forthcoming paper. A consultation with WHO Regional Offices has also been undertaken (Mahmood and Barry, 2009).

In light of the lack of broad representation at the original Galway Consensus Conference, especially from low and middle-income countries, a further consultation and meeting with health promotion representatives from low and middle -income countries is planned in 2010. However, the domains of core competency identified in the Galway Consensus Statement, combined with the feedback received to date, provides a useful framework to guide further developments, including the CompHP project in Europe.

## EUROPEAN DEVELOPMENTS IN HEALTH PROMOTION COMPETENCIES

Health promotion competency development across the individual countries of Europe varies greatly. As discussed earlier, despite the limited development of structured systems in Europe, there are some useful experiences in specific countries on which to build. Some of the work on competencies in Europe is not available in English which restricts description or analysis of these systems for the purposes of this report. Of the European countries with competencies and standards systems, three have information available in English – Estonia, the UK and the Netherlands. Developments in these three countries, with different approaches and systems, can give some further insight into the current situation within at least some parts of Europe (Santa-María Morales et al., 2009).

### Estonia

The Estonian constitution states that the every citizen has to the right to the protection of health. This means the state has an obligation to engage in both health promotion and disease prevention as well as to provide health services and benefits to the population. During the Soviet era health education was part of the health system (Kasmel et al., 2003). Health promotion was non- existent but reforms began at the end of the 1980s and one of these reforms was to establish a health promotion and prevention system (Jesse et al., 2004). In 1993 the Estonian Centre for Health Promotion was founded.

In Estonia health promotion workers have been accredited through their professional organisation, the Estonian Union for Health Promotion, since 2004. The Estonian professional qualification system is divided into five levels where Level 1 is the lowest and Level 5 is the highest (Professional Council for Health Care and Social Work, 2004). The standard is an official requirement of the Authority of Professional Qualification for all professional groupings. The levels of each specific profession including the requirements for education, are determined by the relevant professional council. A formal professional standard was developed for health promotion in 2004 for levels III, IV, V. These are the only levels for a health promotion specialist.

Although entitled a 'standard' the actual content is more like a compact overview of the competencies in health promotion agreed in Estonia. The rationale for the development of the standard was to create a basis for curriculum development for Estonian universities establishing professional programmes in health promotion and for a national accreditation and registration system (Professional Council for Health Care and Social Work, 2004).

The initial draft of the professional standard was drawn up by the Healthcare and Social Work Workgroup, which was established under the Professional Council for Health Care and Social Work. The group was composed of representatives from government ministries, the Estonian Union of Health Promotion and academics from health promotion and related fields. The standards developed for multidisciplinary public health in the UK (Skills for Health 2001, 2004) and the principles and core

competencies of the European Masters in Health Promotion Programme (EUMAHP) informed the developments the professional standard. In 2004, a draft of the standards was circulated to health promotion professionals for comment, and the feedback from this consultation informed the final edition of the professional standard.

The health promotion specialists in III, IV, V professional standard has been formally confirmed by the Professional Council for Health Care and Social Work and the professional qualifications defining the standard have been added to the Estonia national register of professions.

The description of a health promotion specialist within the standard identifies the qualifications required as well as the aims, values and scope of professional practice (Santa-María Morales et al., 2009). A health promotion specialist is defined as a specialist with a degree in higher education and professional qualification, whose professional activities are geared towards the development of the health and life quality of individuals, communities, organisations 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 supportive environments for different social groups to comprehensively develop their health potential and decrease social inequality in health.

The main courses of action, or competencies for the health promotion specialist are listed as:

- Development of the capacities of communities and groups in order to control the determinants of social and physical health that influence the wellbeing of people
- Initiation of cooperation between different sectors to solve local health problems and to advance the health potential of the population
- Development of health related awareness and the social skills of the population and creation of a supportive environment
- Analysis and advocacy of different political decisions and legislation in order to achieve health-supportive decisions and legislation
- Development of peer-support systems and support groups to assist socially vulnerable groups cope and create a social environment necessary for life
- Development of a counselling system concerning health and health services
- Monitoring, analysis and research of the health condition of the population and groups.

A number of personal attributes expected from the health promotion specialist are also specified in the standard. It is presumed that they are tolerant, dedicated, able to work under pressure, empathetic, creative, with a willingness for self-improvement, make decisions independently and with a sense of responsibility, ability to motivate, cooperate and empower individuals and groups.

The current educational requirements for level III professional registration are:

- degree in health promotion OR

- higher education, further training in the field of health promotion (25 European Credit Transfer Accumulation System (ECTS) over the previous five years) and at least five years of working experience in the field of health promotion.

Each successive level requires involves additional educational and work experience, articles published in peer-reviewed journals and evidence of specified points in continuous professional development. The registration system is based on the standards, and individuals can apply for registration once a year. Applicants must present documentation demonstrating their qualifications and employment history to an accreditation committee comprising representations from the university, Health Promotion Union, Public Health Department and Health Development Institute. In 2007, training at bachelor and master's levels in health promotion was established which, it is hope, will increase both the quantity and quality of the health promotion workforce. Future plans include making registration a requirement for employment.

The Estonian professional standard offers a wealth of detail on the professional requirements for health promotion practice and education. Under general knowledge the skills required include human rights, professional ethics and behaviour, health economics, foreign language skills and communication. The health promotion specific knowledge and skills requirement include the philosophy and development of health and health promotion, basics of research, models and theories in health and knowledge of health promotion organisation and structures (national, international and global). These knowledge and skills are further defined into levels of proficiency: basic, intermediate and advanced. The professional requirements are listed in Appendix 8.

## **United Kingdom**

There has been interest and activity in the development of competences and standards in the UK over the past 30 years, including in the fields of health promotion and public health. However, these developments have been complicated by the fact that there are devolved departments of health in the four constituent countries (England, Northern Ireland, Wales and Scotland), different histories and practice in relation to public health and health promotion and the relationship between them, leading to differences in priorities in the development processes of the standards. Changes to the health structures in the early 2000's led to the development of multidisciplinary public health. This overarching approach to delivering public health covers the three elements: health protection, health promotion or improvement and health services. This has added to the complexities of exploring health promotion competencies and standards within the UK.

A number of related, but separate initiatives on skills, standards and accreditation are currently in operation or under development in the UK. These include the Public Health National Occupational Standards (NOS) developed by Skills for Health (2004,

2007), the Public Health Skills and Career Framework (2008) and finally the UK Public Health Register (UKPHR).

As an early development the National Occupational Standards (NOS) for Health Promotion and Care were published in 1997 (Care Sector Consortium, 1997, Department of Health, 1998). Although these standards were extensively piloted (HEA, 1998), they had a short life span but they were later used to inform the development of standards in multidisciplinary public health (Skills for Health 2001, 2004). The National Occupational Standards were developed as a means of improving the capacity and capability of the public health workforce. Following the move to multidisciplinary public health, standards for specialist public health were developed in 2001 (Skills for Health, 2001)<sup>35</sup> and these were followed by standards for practice The National Occupational Standards for the Practice of Public Health (Skills for Health, 2004) which included health promotion. These standards were developed as part of the development of the capacity and capability of the multidisciplinary public health workforce.

The NOS were developed using a multidisciplinary and multisectoral approach and had a wide range of different practitioners from different agencies involved in their development. The standards, among other uses, provide a shared language for partnership working that is capable of being applied to different contexts and different practitioners (Skills for Health, March 2004). The current standards were originally approved in 2004 and were reviewed and restructured in 2007. There are currently 65 different national standards formed into units which make up the overall framework for public health. Each of the units comprises between two and five elements. Each element has a number of performance criteria and a statement of scope/coverage attached to it. The framework presents ten key areas of multidisciplinary public health practice:

1. Surveillance and assessment of the population's health and wellbeing
2. Promoting and protecting the population's health and wellbeing
3. Developing quality and risk management within an evaluative culture
4. Collaborative working for health and well being
5. Developing health programmes and services and reducing inequalities
6. Policy and Strategy development and implementation to improve health and wellbeing
7. Working with and for communities to improve health and wellbeing
8. Strategic leadership for health and wellbeing
9. Research and development to improve health and wellbeing

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<sup>35</sup> Skills for Health is the Sector Skills Council (SSC) for the UK health sector. Its purpose is to help the whole sector develop solutions that deliver a skilled and flexible UK workforce in order to improve health and healthcare.  
<http://www.skillsforhealth.org.uk>

10. Ethically managing self, people and resources to improve health and wellbeing.

Three main categories of the public health workforce are identified as including:

- Wider contributors or professionals who have an impact on public health as part of their work, but who may not recognise this for example, teachers, social workers etc.
- Practitioners – a smaller group of professionals such as health visitors and community workers who spend most if not all of their time in public health practice. These professionals have knowledge and skills in depth for their specific areas and are a vital part of the workforce
- Specialists - the public health consultants and specialists that work at a strategic or senior management level or at a senior level of scientific expertise such as in public health statistics. In the UK, for example, these specialists come from a variety of professional backgrounds such as public health sciences, social science, medicine, and health promotion but all will have a common core of knowledge, skills and experience acquired from postgraduate public health qualifications, successful completion of approved training and experience gained in practice (Department of Health, 2001).

Both specialist and practice public health competencies are currently presented together on the Skills for Health website. The competencies are coded where PHP refers to public health practice and PHS refers to public health specialist<sup>36</sup>. The National Occupational Standards formed the basis for the 'Public Health Skills and Career Framework' (Skills for Health, 2008), for the established regulatory standards for the Public Health Specialist Register and indirectly for the voluntary registration system for practitioner level in public health.

In Scotland, the health promotion section of NHS Health Scotland distilled competencies for health promotion from the UK multidisciplinary framework (Health Scotland 2003, 2005). In 2001/02 the Public Health Institute of Scotland (PHIS) carried out a consultation exercise as part of a process to define the current position of health promotion in Scotland. The working group established to take this work forward, focused its attention on competencies already defined, or being defined by Skills for Health (Healthwork, 2001). A questionnaire listing the competencies was produced and health promotion managers were asked to indicate if each of the functions listed was a function of their department. More general comments were also invited. This process provided further clarity in support of the competencies identified. The core functions were then mapped against the ten agreed areas of public health practice (Health Scotland, 2003).

Based on the ten key areas of practice set out in the Draft Functional Map of Public Health Practice and the Functional Map of Specialists Practice in Public Health, and the core health promotion functions identified by health promotion managers, the group was able to identify a list of competencies (Health Scotland, 2003). Based on the work

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<sup>36</sup> <http://www.skillsforhealth.org.uk/competences/Public%20Health.aspx>



of Bassett (1990) levels were also included. Competencies were then placed within a continuum of practice, reflecting the move from the entry level of the newly appointed practitioner to the core level of the established practitioner and the further progression to advanced which would be available to some. A nationwide consultation through a series of workshops resulted in the development of a draft framework which was distributed for UK wide consultation and Competencies for Health Promotion Practitioners Interim Report of the Working Group was published in September 2003 by Health Scotland. From this the project went into the final phase and aimed to:

- To identify explicitly the range of competencies required by health promotion practitioners (whose main role is health promotion) across a continuum from foundation, through core to advanced level (utilising the national occupational standards for the practice of public health)
- To inform the processes that may be undertaken by other agencies in relation to the local authority health improvement posts and other posts with a similar range of responsibilities.

Some difficulties arose as substantial changes were made in the final version of the report produced by Skills for Health. In early drafts it was possible to differentiate the competencies required by health promotion practitioners who work in specialist health promotion departments from those who have similar but complementary public health roles. By the end of the process, role differentiation was impossible when comparing roles of those who work at a population level (Health Scotland, 2005).

The competencies that were developed distinguished between foundation, core and advanced competencies across the 10 key areas identified (which are identical to SFH) as:

1. Surveillance and assessment of the population's health and well-being (e.g. communicate and disseminate data and information about health and well-being and/or stressors to health and well-being)
2. Promoting and protecting the population's health and well-being (e.g. communicate with individuals, groups and communities about promoting their health and well-being)
3. Developing quality and risk management within an evaluative culture (e.g. contribute to the development of the knowledge and practice of others)
4. Collaborative working for health and well-being (e.g. enable the views of groups and communities to be heard through advocacy on their behalf)
5. Developing health programmes and services and reducing inequalities (e.g. work in partnership with others to plan, implement and review programmes and projects to improve health and well-being and reduce inequalities)
6. Policy and strategy development and implementation to improve health and well-being (e.g. improve health and well-being through policy and strategy development and implementation)
7. Collaborative working for health and well-being (e.g. support communities to plan and take collective action)
8. Strategic leadership for health and well-being (e.g. promote the value of, and need for, health and well-being)

9. Research and development to improve health and well-being (e.g. improve health and well-being through research and development)
10. Ethically managing self, people and resources to improve health and well-being (e.g. promote people's equality, diversity and rights).

This work has now been subsumed into the more current developments in relation to career frameworks and registration in the UK and is, therefore, mainly of use as a reference rather than an active working document. Some health promotion departments in Scotland use the examples under the three levels to help when using the new NHS Knowledge and Skills Framework process for all non-medical/dental and senior management staff in the UK. See Appendix 9 for the full list of these competencies.

In 2005 a report *The Shaping the Future of Public Health: Promoting Health in the NHS* (Department of Health, 2005) which was the result of a collaborative project led by the Royal Society of Public Health aimed specifically to support the specialised health promotion workforce and to contribute to public health workforce development by defining the roles, functions and development needs of staff from a specialised health promotion background within the multidisciplinary framework. Among the recommendations made were:

- Recognition and Advocacy – specialised health promotion should continue to be recognised as a discipline integral to public health
- Improving specialised health promotion capacity – public health teams should endeavour to include, or have direct access to, a critical mass of practitioners with strong health promotion competence, together with access to health promotion advice and support at specialist level
- Career progression – the lack of a clear and recognised career pathway and supporting education and training is a long-standing concern with the specialist health promotion workforce. A career pathway is proposed and a strong practitioner and senior practitioner workforce should be led by a small but important group of health promotion specialists. Skill and competency development should underpin career advancement for specialised health promotion staff within general public health
- Skills and competency development – funded and managed systems are needed for the education, training, development and support of the main health promotion practitioner workforce. Flexible skills and competence development schemes are required for those entering specialised health promotion at first or second degree level (or equivalent) or as a second career. A formal system of continuing professional development should also be introduced
- All specialised health promotion staff should have access to an identified supervisor for professional development. Curriculum development, assessment and accreditation against explicit standards need to continue to be developed, in collaboration with the Faculty of Public Health and other key stakeholders, including academic institutions<sup>37</sup> (Department of Health, 2005).

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<sup>37</sup> <http://specialisedhealthpromotion.org.uk>

In 2006 the Department of Health in England commissioned Skills for Health to develop a career framework for public health to sit alongside career frameworks that had been developed in other areas (Skills for Health, 2007). In developing the Public Health Skills and Career Framework, Skills for Health took the generic National Health Service Career Framework as its starting point, modifying it as the work progressed to ensure that what was developed met the needs of the many agencies and people who contribute to improving and protecting the health and well being of the population. The Skills for Health team worked jointly with the Public Health Resource Unit (PHRU) and the UK Public Health Register to take forward the development of the framework (Skills for Health, 2007).

The public health intelligence area of the framework was developed by the workforce sector of the Informing Healthier Choices Strategy Implementation Group, which is funded by the Department of Health. This information and intelligence workforce group took the lead for piloting the framework with this section of the public health workforce. The development went through a number of stages and iterations including:

- Working with key stakeholders such as the Faculty of Public Health, professional and regulatory bodies and national leads to identify the key competencies and knowledge in their specific areas of work such as academia, health promotion, community pharmacy and so on.
- An initial two-day residential workshop hosted by the SE Regional Public Health Group in July 2006 to initiate the work and develop the first draft of the framework
- Multi-disciplinary and multi-agency workshops held in each of the four UK countries
- Theme specified workshops to focus on the specific content and detail of these areas (Skills for Health, 2007).

The framework was developed over 12 months through 'bottom-up' multidisciplinary and multi-professional stakeholder workshops. These were attended by public health consultants, specialists, and practitioners from a range of different organisations and groups, across the UK. The work drew upon the extensive range of materials already developed by different professional groups and organisations, including the National Occupational Standards, the wider work of Skills for Health on other career frameworks and their links with other sector skills councils.

Following formal consultation, the framework was revised and endorsed by the Department of Health in the UK and the devolved administrations in Wales, Scotland, and Northern Ireland and published (Skills for Health, 2008). In this document the term competence is used. This framework builds on and links to a recent series of successes in strengthening the public health workforce across the UK and reflects the current strong public health policy environment. The framework facilitates collaboration and coherence across the diverse public health workforce through helping to ensure rigour and consistency of skills, competence and knowledge at all levels, regardless of professional background, and through enabling flexible public health career progressions (Skills for Health, 2008).

The Public Health Skills and Career Framework is stated to be for anyone working in the area of public health and any organisation that employs people in public health roles or roles with a public health aspect. It covers the three categories of the public health workforce: specialists, practitioners and the wider workforce (Skills for Health, 2008). Specialists are defined as public health consultants or specialists who work at a strategic or senior management level or at a senior level of scientific expertise such as in public health statistics. Practitioners are a smaller group of professionals who spend most if not all of their time in public health practice. These include those who work with groups and communities as well as with individuals such as the public health work of health visitors. There are also those who use their research, information, public health science or health promoting skills working in specific public health fields. These professionals have knowledge and skills in depth for their specific areas and are a vital part of the workforce (Department of Health, 2001).

The framework is multidisciplinary, UK-wide, and applies to the public health workforce wherever they are based, and whoever their employer may be. The framework is presented as a tool for those in the public health sector who are:

- Working in public health who are thinking about possible career change within the sector
- Wishing to enter the public health domain
- Employers in the public health sector
- Planners in the public health workforce
- Commissioners of training within public health
- Deliverers of training and education in the public health workforce.

The framework defines nine levels of competence and knowledge spanning all nine skills and career levels, starting with direct entry. The knowledge and competencies in four core areas are defined as being required by anyone working in public health. The remaining five non-core or 'defined' areas, representing the contexts within which individuals principally work and practice. Not only is each competence and the knowledge needed to underpin described, but the descriptions are backed by more detailed, discipline specific work (Skills for Health, 2007, 2008). It is recommended that when using the framework the following be taken into account:

- The levels are cumulative. Someone working at a higher level already has, or is able to develop, the competences and knowledge in the statements below that level
- The statements of competence and knowledge capture the nature of working at the level. At any specific level an individual will either have already, or be acquiring with the role, the knowledge and competence described before going on to the next level
- An individual working at a specific level in a defined area as described in the framework has all the core competences and knowledge plus the defined area(s) of competence and knowledge relevant to their area of practice
- Demonstration of ethical management of self is embedded in the core competences

- People using the framework for skills and career development will demonstrate and conform to professional codes of conduct relevant to their own professional group/organisation. Where such codes of conduct do not exist, users will be expected to conform to the Faculty of Public Health code of Good Public Health Practice<sup>38</sup>.

The four core areas of the framework are:

1. Surveillance and assessment of the population's health and well-being. This area of practice focuses on the quantitative and qualitative assessment of the population's health and well-being, including managing, analysing, interpreting and communicating information that relates to the determinants of health and wellbeing, needs and outcomes
2. Assessing the evidence of effectiveness of interventions, programmes and services to improve population health and well-being. This area of practice focuses on the critical assessment of evidence relating to the effectiveness and cost-effectiveness of health and wellbeing and related interventions, programmes and services, and the application to practice through planning, audit and evaluation
3. Policy and strategy development and implementation for population health and wellbeing. This area of practice focuses on influencing the development of policies for improving health and well-being, implementing strategies to put the policies into effect and assessing the impact of policies on health and well-being
4. Leadership and collaborative working for population health and wellbeing. This area of practice is concerned with leading and managing teams and individuals, building alliances, developing capacity and capability, working in partnership with other practitioners and agencies, and using the media effectively to improve health and well-being.

The five non-core areas are:

5. Health improvement. This area of practice is concerned with improving the health and well-being of populations and reducing inequalities by using health promotion, prevention and community development approaches to influence the lifestyle and socio-economic, physical and cultural environment of populations, communities and individuals
6. Health protection. This area of practice is concerned with action for the general environment (e.g. clean air, water and food), prevention of the transmission of communicable diseases and protection against environmental health hazards, through the application of a range of methods including management of outbreaks and other incidents that threaten the population's health and well-being, hazard identification, risk assessment and the promotion and implementation of appropriate interventions

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<sup>38</sup> [www.fph.org.uk/prof\\_standards/general\\_standards/default.asp](http://www.fph.org.uk/prof_standards/general_standards/default.asp)

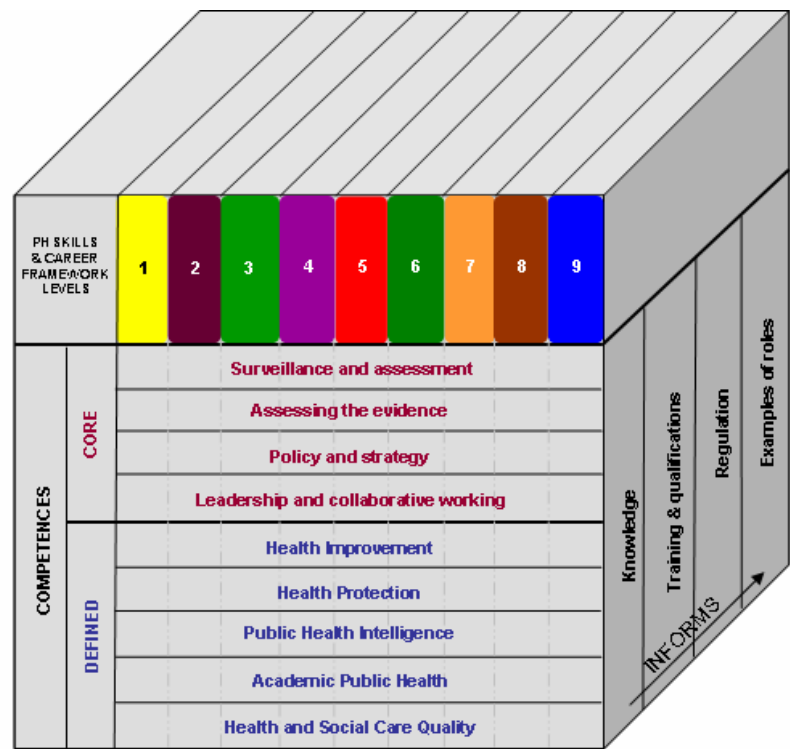
7. Public health intelligence. This area of practice focuses on the systems and capacity to deliver intelligence for surveillance, early warning functions, risk to populations, measurement of health and wellbeing and outcomes. Draw together information from various sources in new ways to improve health and wellbeing
8. Academic public health. This area of practice focuses on teaching of, and research into, population health and wellbeing
9. Health and social care quality. This area of practice covers commissioning, clinical governance, quality improvement, patient safety, equity of service provision and prioritisation of health and social care services.

**Table 3 - Description of the Nine Levels Used in the Public Health Skills and Career Framework (PHRU, 2008)**

Level	Description
Level 1	Has little previous knowledge, skills or experience in public health. May undertake specific public health activities under direction or may acknowledge the value of public health in a wider context.
Level 2	Has gained basic public health knowledge through training and/or development. May undertake a range of defined public health activities under guidance or may use knowledge to influence public health in a wider context.
Level 3	May carry out a range of public health activities or small areas of work under supervision. May assist in training others and could have responsibility for resources used by others. May use public health knowledge to set priorities and make decisions in a wider context.
Level 4	Has responsibility for specific areas of public health work with guidance, which may have a breadth and/or depth of application.
Level 5	Has autonomy in specified areas, continually develops own area of work and supports others to understand it. May contribute to a programme of work in multi-agency or multi-disciplinary environment.
Level 6	Has autonomy and responsibility in coordinating complex work, reflecting wider and deeper expertise in own area of work. Able to develop, facilitate and contribute to programmes of work in multi-agency or multi-disciplinary environment.
Level 7	Has autonomy and expertise in areas of public health. Will lead on areas of work within a defined field.
Level 8	Has a high level of expertise in a specific area of work or across a substantial breadth of service delivery and/or programmes. Is accountable for work across boundaries and agencies. Has leadership responsibility and autonomy to act. Sets strategic direction in own area of work.
Level 9	Sets strategic direction across organisations and/or areas of work. Provides multi-disciplinary or multi-sectoral public health leadership that determines priorities.

The framework consists of the collection of competence and knowledge statements for each area and level and it may be represented as a three-dimensional cube

Figure 2 - The Public Health Skills and Career Framework Cube (PHRU, 2008)



Following formal consultation, the framework was revised and endorsed by the Department of Health in England and the devolved administrations in Wales, Scotland, and Northern Ireland.

The UK Public Health Skills and Career Framework, may be a useful tool in the development of competencies in health promotion as it allows for ‘matching’ of competencies for the workforce as a whole and not for individual practitioners. The format used for the National Occupational Standards (NOS) has, however, been described, as being overly complex (Health Scotland, 2003) and the fact that health promotion is not made explicit may limit their usefulness in developing international core competencies (Battel-Kirk et al., 2009). The full list of competencies is available in Appendix 9.

Finally the UK Public Health Register (UKPHR) has registered and regulated Public Health Specialists since 2003. In 2008 there were 360 public health specialists registered including a small number of specialists in health promotion, and it is envisioned that numbers will increase in the coming years (Santa-María Morales et al., 2009). A review of the Regulatory Framework for Specialists in Public Health is currently underway. Practitioners are referred to in the terms of reference and the UK Register Board have agreed to delay the possible introduction of the practitioner registration. The Faculty of Public Health in the UK are also considering a category of membership at practitioner level.

## The Netherlands

The Netherlands Institute for Health Promotion (NIGZ)<sup>39</sup> supports professionals and organisations with the development and implementation of health promotion. The Dutch Association for Health Promotion and Prevention (NVPG) is a small voluntary organisation with approximately 500 members. The aims of the NVPG are to:

- Maintain and improve the quality of the profession
- Facilitate professional development and exchange of ideas and information.

A health promotion professional, as defined by the NVGP, has a bachelor's or a master's degree and spends 50% or more of their time on health related tasks, as described by the NVPG. Health promotion practitioners work in a number of areas including: municipal health services, mental health, home care, substance abused, research and policymaking. Health promotion practitioners are described as working in the triangle of practice, policy and research and work intersectorally and in collaboration with private partners. Their function is to promote healthy behaviour and a healthy environment and try to establish a connection, if relevant, between prevention and care.

There is an established registration and accreditation system for health promotion practitioners in The Netherlands which is administered by the NVPG. This system was developed in the context of long-standing discussion and action on quality of care at national level for all health related professions from the 1880s onwards. In the 1980s the discussion on quality of care at national level for all health related professions in the Netherlands began and this was followed by a series of initiatives including the Quality of Care Act (1996) which required all health institutions/ organisations to offer accountable care and to do this in a systematic and visible manner. In 2003 this act was amended to include all public health tasks, including health promotion.

The Inspection of Health Care launched a report in 2000 concerning the quality of health promotion and this gave a greater sense of urgency to developing an accountable system for health promotion as it was found that the sector was complex and diffuse with great diversity in job roles, task descriptions and was made up of a heterogeneous group of professionals. The report found that it was not clear what health professionals did, how they did it and how they were qualified to do it. The report indicated that health promotion professionals needed to redefine health promotion tasks, develop job profiles and legally establish professional standards, in line with other disciplines (Inspectie voor Gezondheidszorg, 2000).

The National Taskforce on health promotion was established in 2003 with the aim of to improving the quality of health promotion. A functional map for health promotion in this setting was developed and the knowledge, skills, attitude and education required by those undertaking these functions were formulated. This document formed the health promotion standards for the Inspectorate of Health and was the

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<sup>39</sup> <http://www.nigz.nl>



basis for a health promotion certification scheme for organisations developed by a national centre for quality review in health care in 2005<sup>40</sup>.

Recently the Inspection of Health Care delivered a new report on public health (2010) in which progress was observed. However the inspection was still critical on some elements in local health promotion<sup>41</sup>. Another recent development in quality improvement has been the establishment of the national Centre for Healthy Living (CGL) of the national institute for public health and environment (RIVM) which will concentrate on the quality of interventions in health promotion<sup>42</sup>.

Many of these developments have focused on organisational quality improvements, however the NVPG recognised its responsibility as a professional body to focus on the quality of the profession and the professional in practice. In 1999, the beginnings of a registration system was established after it was decided that an accreditation system was the best way to promote quality standardisation of the profession.

A professional profile is the backbone of the NVGP system, based on the 'products and core functions' of health promotion identified for the certification scheme for Municipal Health Services:

*Products and core functions of health promotion*

- Policy advice and providing information
- Plan and implement health promotion programmes
- Facilitate and support health promotion processes
- Research and development
- Improve the promotion and prevention structure (partnership building).

For each of these functions there is a detailed list of required tasks. All activities that are registered are reviewed on the basis of this profile by the registration and accreditation committee of the NVPG. A number of key principles were agreed for the system including that it should:

- Be clear and relevant to practice
- Reflect a minimum standard for professional development
- Be flexible and offer members several possibilities to meet the requirements
- Be considered as an integral part of the NVPG quality system.

Based on these principles, a phased introduction to a voluntary registration system was agreed with a low entrance level to encourage uptake. Phase 1 consisted of every member of the NVPG being given the opportunity to become a registered member until July 1999 without any other requirements.

In phase 2, requirements for registration increased to include membership of the association and attendance at a specific lecture given annually. For phase 3, the requirements for registration rose to having to attain 15 points over two years, in

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<sup>40</sup> <http://www.hkz.nl/content%20view/52/149/>

<sup>41</sup> [http://www.igz.nl/zoeken/document.aspx?doc=De\\_preventiecyclus](http://www.igz.nl/zoeken/document.aspx?doc=De_preventiecyclus)

<sup>42</sup> [http://www.rivm.nl/en/aboutrivm/organization/public\\_health/CGL/index.jsp](http://www.rivm.nl/en/aboutrivm/organization/public_health/CGL/index.jsp)

addition to membership. For example attending a training course, congress or conference would merit 1 point per hour and publishing an article in a scientific journal would earn you 16 points if the 1<sup>st</sup> author and 8 if the 2<sup>nd</sup> author. The current phase is phase 4, with the following criteria for registration:

- Membership of the NVPG
- Bachelor's degree
- 90 points acquired within three-year period.

The registration and accreditation system is operated almost entirely via the NVPG website<sup>43</sup>.

Providers of education in the field of health promotion can also register for accreditation of courses using a protocol developed by the NVPG. The main area identified for future action on registration is to increase the number of health promotion practitioners registered. The long-term goal is that only registered health promotion professionals will be employed in the field. However, the association identifies barriers which may limit future development, notably the fact that the NVPG is a voluntary organisation with limited capacity and resources.

The NVPG has developed a practical, structured and flexible registration and accreditation system for health promotion. The easily used web-based system has much to offer as a model for a pan-European system. The phased introduction may also be a useful approach when working with a diverse workforce that will have differing levels of support and resources to develop and access accreditation system.

### **Developments in Other European Countries**

Capacity building and awareness of the benefits of the development of competencies for health promotion practice has been recognised to different degrees in many other European countries. However, the level and extent of developments have been very varied and mixed. It is useful to explore the current levels of development in relation to health promotion in a number of countries and link this to the development or otherwise of competencies.

Malta: the Department for Health Promotion and Disease Prevention within the Ministry of Health is the official public entity responsible and *'strives to enable the people of Malta and Gozo to increase control over the determinants of health, live healthier lifestyles and so improve their health. It works within settings such as schools, workplaces, communities and cities that offer practical opportunities for the implementation of comprehensive strategies'*<sup>44</sup>. Meanwhile, a lot of Health Promotion interventions are carried out by various professionals such as care givers and social workers as well as a number of non-governmental organisations and charitable institutions.

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<sup>43</sup> <http://www.nvpg.net/index.cfm?page=home>

<sup>44</sup> <http://www.sahha.gov.mt/pages.aspx?page=295>

Health education and promotion are embedded within the principles and objectives of the Maltese National Minimum Curriculum from primary school through to secondary school by taking into consideration all the determinants of health and by aiming to provide the knowledge, skills and attitudes pupils need to be empowered over their health <sup>45</sup>. Home Economics teachers are well-trained at university level to face this challenge, having a very strong health education and promotion component in the B.Ed. (Hons) Nutrition, Family and Consumer Studies programme which focuses on the individual, consumer and family well-being. Teachers are given initial training to become health educators in the school setting and beyond (e.g. community and mass media). At postgraduate level, through the M.Ed Health, Family and Consumer studies programme the teachers' content knowledge and communication skills are strengthened, while giving emphasis to community development programme planning, implementation and evaluation, as well as an introduction to social marketing and policy development<sup>46</sup>. Home Economics graduates are often the ones to take up the role of Health and Safety teachers in schools, are actively engaged in the planning and implementation of health promotion strategies such as the 'Healthy Eating Lifestyle Plan' (HELP) school policy. In addition, the Home Economics Seminar Centre has been entrusted as one of the key players to provide guidance and support for the implementation of HELP in schools. The same centre runs workshops for school children and their parents on-site at the Seminar Centre, or off-site in schools, day centres for the elderly, parish groups and other community. Home Economists in Action is the local teachers association which provides Continuing Professional Development opportunities for teachers, as well as organising public lectures and events with a clear emphasis on health promotion.

The Health Promotion and Disease Prevention Directorate and the Nutrition, Family & Consumer Studies office within the Faculty of Education at the University of Malta have met recently to discuss the way forward in developing health education competencies for Maltese professionals, and providing and ensuring the appropriate training.

Medical students can also study health promotion through the two-year part-time course run by the Department of Public Health leading to a Masters Degree in Public Health Medicine. The course covers research methods including epidemiology and qualitative research, medical statistics, health information science, health promotion, organisation of health care systems and management, environmental health, sociology of illness, applied epidemiology, communicable and non-communicable diseases, social policy and health economics <sup>47</sup>.

Ireland: there has been considerable progress and investment in Health Promotion development over the thirty years. The Health Education Bureau was established in

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<sup>45</sup> [http://www.curriculum.gov.mt/docs/nmc\\_english.pdf](http://www.curriculum.gov.mt/docs/nmc_english.pdf)

<sup>46</sup> (<http://www.um.edu.mt/educ/courses/postgraduate>)

<sup>47</sup> <http://www.um.edu.mt/ms/courses/postgraduate>

1975 and this was then replaced in 1988 by the Health Promotion Unit which was a policy and executive section within the Department of Health and Children. The Chair of Health Promotion and the Department of Health Promotion, National University of Ireland Galway (NUI Galway) was established with the support of the Department of Health as part of a revised National Structure for Health Promotion in 1990. Within the Health Service Executive (HSE) in 1995 dedicated health promotion posts were established and since then dedicated teams of health promotion staff are employed at HSE regional levels.

Health Promotion is now firmly established at university level with four undergraduate courses and six postgraduate courses offered in Health Promotion throughout the country. In addition, the Association for Health Promotion, Ireland (AHPI)<sup>48</sup>, was formed in 1997 and is a national forum through which a range of expertise and experience in the fields of health promotion and health education can be shared. Membership is voluntary and the AHPI is a member of the International Union of Health Promotion (IUHPE).

Training and development of health professionals was recognised as being essential to the development of health promotion programmes in the health services in the National Health Promotion Strategy (Department of Health, 2000). A review of the National Health Promotion Strategy (McKenna et al., 2004), stated there was a skilled and competent workforce in place, many with dedicated postgraduate level training in health promotion to master's level. Therefore, the knowledge and skill base is strong and levels of commitment and innovation are high and this provides a very good base for sustaining and further developing current levels of activity. The review also noted that there is a need to enhance the leadership and expertise at national and regional levels to strategically direct the national health promoted agenda in line with best international practice. The review recommends that there be continued investment in resources, both in terms of strategic leadership at national and regional levels and capacity building for the health promotion workforce (McKenna et al., 2004).

The current chair of health promotion in NUI Galway is also the Global Vice President for Capacity Building, Education and Training in the IUHPE and one of the objectives for the period 2007-2010 was the development of international collaboration on producing a consensus statement on health promotion core competencies (Barry, 2008). The Galway Consensus Conference was held in NUI Galway in June 2008. Irish practitioners, policymakers and researchers in health promotion were engaged in a consultation process immediately after the meeting to discuss their views on the Consensus Statement and its relevance to the Irish context.

Other developments which have some relevance for the development of health promotion competencies in Ireland include the development of competencies by the Faculty of Public Health in the Royal College of Physicians in Ireland. Fellows of the college are required to maintain these competencies through continuing medical

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<sup>48</sup> <http://healthpromotionireland.com/>

education as laid out in the Medical Practitioners Act 2007. These public health competencies are currently under review<sup>49</sup>.

Spain: regional agencies are responsible for accrediting professional development and this includes health promotion in some regions, and includes practitioners with different backgrounds within the health and education sectors (Santa-María Morales, et al., 2009).

The developments to date have included the following:

- Consensus-building process, coordinated by the Ministry of Health, to define the quality standards for health promotion training at different levels: undergraduate, postgraduate and continuous professional development
- Development of an information system that comprises a database on health promotion interventions, training, publications, professionals and the institutions where health promotion is practised across all the autonomous communities (regions)
- A consensus-building process, initiated by the professional societies of public health, to agree the core competencies required for public health professional performance (Benavides, et al., 2006).

These developments formed the basis for the current official training programme for medical specialists in public health, and health promotion is recognised within the required set of knowledge and skills (Santa-María Morales, et al., 2009).

Italy: health care is provided through the Italian National Health Service (Servizio Sanitaria Nazionale (SSN) which is a government funded organisation that provides medical care as well as other socio-psychological intervention to the population. The health services are delivered through a number of regional health agencies (Agenzia Sanitaria Locale - ASL) who operate independently and have responsibility for their own budget and delivery of services.

The Experimental Centre for Health Education of the Population was established at the University of Perugia in 1954 under the auspices of the World Health Organisation (WHO). The *Comitato Italiano per l'Educazione Sanitaria* (Italian Committee for Health and Health Education) was also founded around this time. The aim was to guarantee technical collaboration between the various organisations and voluntary groups who worked in health including areas such as education, community care and prevention. They also aimed to facilitate the exchange of information, encourage research and to contribute to public information regarding physical and mental health problems. This committee is now the *Confederazione Italiana per la Promozione della Salute e l'Educazione Sanitaria* or *CIPES* (Italian Confederation for Health Promotion and Health Education) The CIPES is a founding member of IUHPE and the seat is at the *Centro Sperimentale per l'Educazione Sanitaria interuniversitario* or *CSESi* (Experimental Centre for Health Education) at the University of Perugia (IUHPE, 2001)<sup>50</sup>.

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<sup>49</sup> <http://www.rcpi.ie/Faculties/Pages/FacultyofPublicHealth.aspx>

<sup>50</sup> <http://www.unipg.it/csesi/ita/welcome.htm>

The confederation periodically organise conferences, seminars and conventions. In addition members can participate in assemblies, receive newsletters, participate in study groups and access materials and publications. They also translate international research into Italian.

The National Health Plan was published in 1994 and this was the first time that health promotion was explicitly introduced as an intervention strategy<sup>51</sup>. The first educational training course in health promotion was established in Italy by the University of Perugia (Università degli Studi di Perugia) in 1990.

DoRS is a regionally financed organisation in Piedmont and was founded in 1998. It provides documents and material to the *Agenzie Sanitarie Locali* (ASLs) for health professionals, researchers, labour unions, teachers, community organisations and local provincial and regional policy makers. In addition to disseminating literature, they are also involved in training professionals and decision makers to develop the skills and knowledge necessary for health promotion practice. They also assist in the design, implementation and assessment of health interventions, projects and policies. DoRS actively cooperate to develop networks at local, regional, national and international level<sup>52</sup>.

The Department of Public Health in Piedmont, DoRS in collaboration with the University of Turin developed competencies for students doing a Master's degree in Health Promotion, Prevention and Nutritional Education (Piemonte Region, 2005).

The document '*Construire un profile di competenze per gli operatori della promozione della salute*'<sup>53</sup> outlines the necessary competencies required by graduates who have completed Level II (three year degree with two years of specialisation). The functions are :

1. Conduct an individual and community needs assessment
2. Plan/design effective interventions
3. Implement health promotion interventions
4. Evaluate the theoretical and practical efficacy of the health promotion intervention
5. Manage health promotion activities effectively
6. Provide information and advice for the development of health promotion projects
7. Communicate effectively in relation to health, needs and resources
8. Apply the appropriate principals and methods of research in health promotion. See *Appendix 10 for the full list of competencies*.

In the past few years the course prospectuses for the Degree in Medicine within the Faculties of Medicine all over Italy have undergone a reorganisation to cater for present and future needs in the health sector. Health promotion is considered a core component of this new curriculum structure demonstrating increasing awareness and

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<sup>51</sup> <http://www1.american.edu/academic.depts/cas/health/iihp/iihpcpitaly.html>

<sup>52</sup> <http://www.dors.it>

<sup>53</sup> [http://www.cipespiemonte.it/cedo/allegati/2132\\_giacchiform.pdf](http://www.cipespiemonte.it/cedo/allegati/2132_giacchiform.pdf)

that health promotion is crucial for the preparation and training of physicians.

Other courses offered in Italy include the Master's in Health Promotion planning, implementation and evaluation at Perugia University<sup>54</sup>. Health promotion courses are also offered in Sienna, Turin, Cagliari, Milan and Rome.

Finland: as reported by the WHO (2002), it is acknowledged as one of the world's leaders in the field of public health. In addition to this Finland has often requested external reviewers to examine its achievement, progress and problems in public health. These reviews are used as a learning tool not only in the national interest but also to be shared internationally. At a health policy and organisational level in Finland a high level of strategic thinking in the area of health and sustainable development are characterised by articulation into systematic planning and reporting. The World Health Organisation was invited to carry out a review and in 2002 they published the *Review of National Finnish Health Promotion Policies and Recommendations for the Future*.

In the national public health programme *Health 2015* it was stated that when training health care professional training should give greater attention to health promotion (Rautio, 2006). One of the recommendations in the WHO review was to ensure the numbers, skills, strengths and preparedness of human resource capacity at all levels, for both strategic planning and management functions and for implementation (WHO, 2002).

With both these reports in mind Rautio (2006) reviewed health promotion training in educational establishments in the health and social services sector. The principal purpose of this study was to identify development needs in order to strengthen health promotion expertise in training programmes in the health and social services sector. The report was based on the international definitions of skills requirements in health promotion. It was found that the most important development needs concerned the following topics:

- Defining health and health promotion
- Specifying the responsibilities and roles of each sector in health promotion issues
- Improving methodology skills particularly in community and environmental health promotion and in the reduction of health inequalities
- Practical implementation of national and international programmes based on each sector's special requirements
- Strengthening public health thinking and societal approaches.

The report also identified the strengths of each education sector and level and recommended that co-operation between different education sectors and levels needs to be improved to enable research-based good practice to be utilised more extensively. In general, continuing education in enhancing health promotion expertise and trainers' skills were identified as needing to be strengthened.

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<sup>54</sup> [www.unipg.it/csesi](http://www.unipg.it/csesi)

Identifying the skills, both basic and specific, required to work in health promotion settings has also been addressed by Tuominen et al., (2005). In the book *Key Areas of Health Promotion in Non-Governmental Organisation's Health Promotion Education*, these skills are identified: Basic skills include:

1. Communication skills
2. Workgroup skills and
3. Project management.

Specific skills include:

4. Theoretical knowledge
5. Pedagogical skills
6. Planning and implementation of health promotion programs
7. Evaluation skills
8. Research skills and
9. Topics in the field of health promotion.

France: health education and promotion covers a set of activities carried out by various professionals such as care givers, social workers and teachers and at least 40 professions are involved in health education and health promotion. As explained by Hamel et al., (2009), the role of the National Institute for Prevention and Health Education (*INPES – Institut National de Prévention et d'Éducation pour la Santé*) is to draw up health education training programmes every five years. The committee with responsibility for these programmes has adopted a competency-based approach and they aim to develop a framework for competencies which will be common to all professionals involved in health education, regardless of their sector in which they are working e.g. health, social services, education etc. This framework can then contribute to the training standards for these different skills and qualifications in a way that promotes the integration of the teaching of health education (HE) and therapeutic patient education (TPE) into existing training (Hamel et al., 2009). As part of this process INPES carried out a review of existing competency models and standards. For this review they analysed the international frameworks of US, New Zealand, Scotland, Australia, Canada, the UK, the work of ASPHER and the IUHPE through the Galway Consensus Statement.

Although no formalised standards were identified in France some documents that detailed capabilities, skills or attitudes were included. An article by Ferron (1999) *Developing health education training: objectives and strategy*, led by the French Committee for Health Education (*CFES – Comité Français d'Éducation pour la Santé*), highlighted the skills for health educators that reflect the theoretical and practical foundations, determinants for behaviour and consider the personal and social context of people. A list drawn up by SOPHE is attached to the document. These ten areas of responsibility are divided into the skills and sub-skills that health educators need to master:

1. Assessing individual and collective needs within health education
2. Planning effective health education action
3. Implementing health education action
4. Evaluating the effectiveness of health education action



5. Co-ordinating the provision of health education services
6. Acting as a health education resource person
7. Communicating with regard to needs, requirements and resources within health education
8. Application to health education of appropriate research principles and methods
9. Managing health education action
10. Progressing as a profession.

A 2002 report by Sandrin-Berthon *Éducation pour la santé, éducation thérapeutique : quelles formations en France? État des lieux et recommandations* (Health education, therapeutic education: what training in France? Status of locations and recommendations) listed the following competencies for training:

- Locating action within a global health promotion policy
- Analysing the institutional context operated within, understanding the different approaches in place
- Planning action programmes
- Taking into consideration the physiological, psychological, social and cultural characteristics of people worked with
- Choosing, using, sometimes designing pedagogical methods and tools adapted for application with the public and within the framework of operation
- Expressing oneself clearly orally and in writing, using different channels of communication
- Working in partnership with other professionals
- Evaluating the effects of the education at a pedagogical and health level.

A study looking at defining the role for health educators and promoters *Rapport final de l'étude métier (ingénieur Conseil enEPS)* examined the defining role of health education consultants and advisors with the FNES network. The following six areas of activity are identified:

1. Contributing to the drawing up of health policies within an area of operation, providing elected representatives and institutional managers with information to reflect upon and help with decision-making  
Key competency: Being able to guide public decision-making in the area of health promotion and education
2. Designing, implementing and evaluating innovative action and experimental projects based on the participation of the public and partnership work, carrying out studies and research, taking action in response to health promotion and education development needs  
Key competency: Being able to carry out projects and research/action within health promotion and education
3. Co-ordinating, developing and leading partnerships for action linked to the deployment of health plans or programmes in the area of operation

Key competency: Being able to co-ordinate and lead partnerships and networks of prevention and health promotion and education practitioners

4. Advising and providing methodological support for project sponsors, and prevention and health promotion and education action, for all of some of the roll-out phases of a project, from help with launching to support for evaluation

Key competency: Being able to support project sponsors or prevention and health promotion and education action

5. Designing, implementing and leading initial training and continuing education for health, health professionals, and educational and social service practitioners

Key competency: Being able to design and lead training within health education

6. Capitalising on and taking full advantage of the result of, and lessons learned from, action taken, within a context of the creation and transfer of knowledge, methods and tools intended for the wider public or for health professionals and educational and social service practitioners

Key competency: Being able to produce educational resources within health promotion and education.

However, despite these examples no formalised standards based on a robust methodology has yet been identified in France (Hamel et al., 2009).

Portugal: Although, specific competencies in health promotion have not yet been developed in Portugal, interest in competencies is developing. A paper by Louriero (2009) looks at the evolution of health promotion and the role of competencies in this development and how important it is for those working in health promotion to develop the necessary skills. However, in Portugal there has been a lack of consistent investment in health promotion and it is recommended that a health promotion strategy be developed. The importance of multidisciplinary work and the development of competencies are two of the pillars seen as being key to the future of health promotion in Portugal.

Poland: since the mid 1980s, the Department of Public Health and Health Promotion is responsible for developing public health strategies as well as policy and programmes at both national and community levels. The Department of Public Health and Health Promotion is part of the Chief Sanitary Inspectorate (ChSI) which is a branch of the Ministry of Health.

Currently public health is in a state of transition due to the rapidly changing demands of the health systems and the introduction of reforms (Burazaer et al., 2005).

Health promotion is a prime example of these changes and reforms. Previously it was considered to be under the remit of the sanitary and hygiene organisations that operated at regional levels, but nowadays health promotion is developed at national level.

Cianciara (2009) examined the core competencies that existed internationally in public health and compared them with Poland. It was found that Polish public health graduates did not cover the full range of functions and skills identified in other countries. One of the explanations for this is that the essential functions of the Polish public health system have never been officially defined and the author concluded that there is a need to have a national debate on this matter and educational standards need to be modified accordingly.

Public health research and training had traditionally been located in medical universities (De Leeus, 1995) but now training based on the new public health is emerging. In the Polish formal Classification of Occupations in Poland (consistent with ISCO) both 'health promoter' and public health specialists are recognised occupations. There is a specialisation in public health and also one in health promotion and education but public health training is much more established. However, since the publication of the Galway Consensus Statement this document has been used to inform the development of new curriculum for health promotion and health education post-diploma training in Poland.

Croatia: in the past health education has been seen as being part of the role of doctors though in more recent years some health education content has been integrated into the school curriculum (Puharic et al., 2006). In recent years the idea that behaviour is greatly influenced by the social context in which people lead their lives is demanding a new approach to health and health system policy development leading some to call for a reorientation of the health services (Sogoric et al., 2002). The bottom up approach is now supported in initiatives such as the Healthy Cities project and a multi-disciplinary and intersectoral approach is called for (Sogoric et al., 2005).

In *Communication to the Specialist Section of Public Health - Santé Publique of the Union Européenne des Médecins Spécialistes (UEMS)* in 2001 Dr Iain J Robbé identified a list and definition of competencies necessary for public health medicine. Health promotion was identified as one of these competencies (see Appendix 11). After the recommendation of the Croatian Association of Public Health these competencies became part of the of the specialist training programme in Public Health Medicine. Health promotion is studied as a core area of public health in Croatia. Both medical and non-medical students are accepted for the Masters in Public Health at the Andrija Štampar School of Public Health and students have to demonstrate understanding of the three main public health specialist areas:

- Health promotion
- Disease prevention
- Health care system organisation and quality management.

A list of competencies has been drawn up by the university, to reflect the knowledge and skills the students should acquire after completion of this Master's programme (see Appendix 11). There is a distinction between non-medical students (Masters Public Health) and medical students (Consultants in Public Health Medicine. The level required for non-medical students is level one whereas medical students require levels two and three.

The health system in Bulgaria and other eastern European countries has gone through a number of reforms in recent years. Health promotion which was previously an unfamiliar concept has made advances (Georgieva et al., 2007) and there has been a growing interest in health promotion capacity building. Specific developments in competency development, however, have not as yet been published.

There are a number of developments in many other European countries for which information in English was not available for the purpose of this review.

## **DISCUSSION**

This discussion section examines the commonalities across frameworks, the methodologies used in their development and the critical issues arising which have implications for the development of a pan-European competencies framework.

### **Commonalities across Frameworks**

The following Table 4 presents the main themes that emerged from the different competency sets. The core domains as identified in the Galway Consensus Statement were checked against the most commonly identified domains or themes emerging from the competency lists compiled internationally and in Europe. This table was then used as the basis for the main mapping exercise where individual competency statements were mapped in a more expansive way.

The intersectoral, collaborative and multidisciplinary nature of health promotion is evident in the range of varied competency sets reviewed. Given that there are differences between countries, not only in the terminology used in the field of health promotion, but also in how health promotion is practiced and how the workforce is defined, one might expect differences between the frameworks. Despite the differences, however, all frameworks reflect the common concepts, principles and values of health promotion practice. While it is true to say that the frameworks do not present a 'one size fits all' they do share many common features.

Broad domains of competencies emerged and were apparent across the frameworks. There was some variation in how some frameworks considered certain areas to be core, whereas in others these areas were considered to be a competency within a wider domain. For example, in New Zealand partnership and collaboration were seen as competencies within the domain of programme/project planning. Some considered planning, implementation and evaluation as the one core area, where others considered them separately. Communication was considered across most sets but this had not been identified as a core domain in the Galway Consensus Statement. For the purposing of this exercise the definition of catalyzing changes was expanded to the broader understanding of enabling change/empowerment. The principle domains identified included: needs assessment, planning, evaluation, advocacy, partnership/collaboration, and communication.

The themes of social justice, equity, equality, and cultural diversity are evident through much of the competencies identified but are not necessarily considered to be core. New Zealand does, however, have a specific cluster of competencies around cultural diversity and although Australia have developed cultural competencies they are not directly linked to the health promotion competencies reviewed for this paper. Other frameworks such as Scotland, Australia, Israel, and the UK do address cultural diversity in some of the competency statements.

The ethical dimension of health promotion is evident in the Ottawa Charter (WHO, 1986) and this is a common theme reflected in the competencies. Ethical frameworks were developed to complement the competency frameworks in the US and Australia. Section two of the New Zealand framework outlines the values and ethical principles of health promotion practice as recognised globally and provides a vision of ethical practice relevant to the unique context in New Zealand. The Scottish health promotion framework also devotes a full domain to working ethically.

**Table 4 - Comparison of Competency Domains Across International Frameworks**

Core Domains	Aus	NZ	Canada	USA	UK	Scotland	GCS	Aspher	Phetice
Catalyzing Change			√			√	√		
Leadership/management		√		√	√	√	√	√	√
Needs Assessment	√		√	√	√	√	√		√
Planning/development of evidence based programmes	√	√	√	√	√	√	√	√	√
Implementation	√	√		√	√	√	√	√	√
Evaluation	√	√		√	√	√	√	√	√
Advocacy		√	√	√			√		
Partnership/collaboration	√		√		√	√	√		√
Cultural understanding, relevance and sensitivity		√							
Ethics	√	√		√					
Inequality / equity						√			
Technology	√								
Communication	√	√	√	√		√		√	√
Knowledge (Health promotion models, theory, research and policy)	√	√	√		√			√	

Some frameworks, such as Australia, New Zealand and Canada were specifically developed for use by health promotion practitioners and in all of these countries the process was guided by established professional organisations that supported and steered the developments. This was also true of the development of the health education competency project in the US. Nevertheless there was also the recognition, as explicitly stated in the Canadian framework, that the competencies were not intended to exclude individuals who had a health promotion role, but worked in other settings. Similarly the New Zealand framework recognised that people working in health promotion come from a variety of backgrounds, are employed in a variety of settings and do not necessarily all identify as health promoters.

The level of detail varies across the frameworks and this, in some ways, was affected by the target audience of the framework. The frameworks for Canada, New Zealand, Australia and the US were geared towards a defined health promotion/health education workforce, whereas in the UK the framework was multidisciplinary and targeted the entire public health workforce and thus required much more detail. New Zealand competencies also distinguished between 'knowledge' and 'skills' and developed clusters for each. Levels of proficiency were used in the US, UK and New Zealand resulting in more detailed frameworks. The Australia framework specifically states that it is for entry level health promotion practitioners and is very easy to read and user friendly. It is difficult to judge how much detail is the most appropriate. If frameworks are detailed they have the advantage of presenting clear and detailed statements which are unambiguous, however, if they are overly complex, they may be unwieldy to use. If they are simple they can be seen as easy to use and can be contextualised within different settings but then they may have the disadvantage of being too simple and may not provide enough substance and detail to make them practical for use.

The role of competencies in informing the structure and content of health promotion training programmes was identified in a number of frameworks. The first Australian development (Howat, 2000) successfully mapped the competencies to a university training course. ASPHER, PHETICE and ASPH sets were all developed with the objective of informing the development of training and curricula for the public health workforce. The competencies identified by the University of Siena were also to guide university health promotion training. In Canada the academic competencies used by the University of Toronto's health promotion programme were used to inform the development of the workforce competencies.

Some of the frameworks reviewed were targeted more at a public health workforce but health promotion often emerged as a theme or common thread running through them. In the ASPHER competencies health promotion competencies were a sub-set of public health. Both health promotion and public health are identified in the PHETICE model. In New Zealand the public health competencies were developed after the health promotion competencies and provide a minimum baseline set of competencies that is common to all public health roles across all public health sectors. The health promotion competencies sit on this baseline (Public Health Association of New Zealand, 2007). This is also true of Canada where the health promotion competencies were developed after public health

competencies and they describe the skill set that constitutes the 'value added' that health promoters bring to the field of public health (Hyndman, 2007).

Competency development is an evolving process. In Australia the competencies are reviewed on a regular basis to reflect the changes in a dynamic profession. In the UK changes in how health promotion and the public health workforces are defined has resulted in a number of separate but related initiatives regarding the development of competencies and standards. In the US health education competencies are also regularly reviewed.

This review demonstrates that there is a large body of work available and that these frameworks have much to offer in informing the development of core competencies in Europe. Many countries have not started the process of competency development and the levels of development across countries is quite varied. In addition, the frameworks reviewed vary in their format, the terminology, degrees of complexity and even in what they consider to be core domains. Therefore, it is quite difficult to marry either competency sets or discrete elements to make a new set of competencies. This creates a challenge for developing European level competencies that are broad enough to be relevant to a wide-ranging audience while still being robust and meaningful. In this context it makes sense for the CompHP project to build on the development of core competencies to date and to adopt the best of the frameworks, processes and methodologies that have been used to successfully identify and build consensus for health promotion competency development.

### **Methodologies for Developing Competencies**

This literature review demonstrates some of the different methods that have been used to develop lists of competencies and the diverse processes for reaching consensus about them. Differences emerge in the methods used, but many common elements may be identified. These will now be described.

A literature review is the most commonly used starting point (McCracken et al., 2000; Health Scotland, 2003; Shilton et al., 2003, 2005; Moloughney, 2006 and Melville et al., 2006). A literature review will inform the researcher not only on the approaches used in relation to developing the competencies but can also give important information on the health promotion workforce and setting. This is important as countries with similar systems can benefit from flaws highlighted or gaps identified in previous studies. In addition, a literature review will add to the theory base and enhance the understanding and knowledge of the field of competency development. Finally the information gathered from the literature review can provide a focus and starting point and guide in the development phase of similar projects.

Reviewing the existing competency sets are an important part of this review and Moloughney (2006) advises highlighting items of particular importance for further description. When reviewing these sets Moloughney (2006) advises asking the questions:

- Do they provide the additional detail and address gaps of concern?
- Do they provide the additional depth and breadth desired to capture health promoter competencies?



At this stage some may decide to carry out an information gathering exercise. The purpose of this is to focus on what actually happens in practice. This activity can be carried using a number of methods but involves some sort of consultation such as workshops as used in the UK or think tanks as in New Zealand. This can also include observing or interviewing or both an 'exemplary' practitioner to identify the actions, content and context involved in their 'exemplary practice' (Centre for Health Policy, 2008). Many frameworks used a questionnaire for gathering information e.g. the EUMAHP project. The ASPHER project invited schools of public health to submit lists of competencies that they felt were important (Bird and Foldspang, 2009). Other initiatives undertook surveys of a representative sample of practicing professionals to determine what they actually do in practice as they did in Scotland and the US (Health Scotland, 2003, Gilmore et al., 2005).

Mapping exercises have also been used (Meresman, 2004; Health Scotland, 2003) where mapping the domains and competencies can help identify what is considered to be core in other settings. Functional analysis is also used in developing competencies (Skills for Health, 2001, 2004). Functional analysis can be used to try and explain a recurrent activity or behaviour pattern in individuals or groups. It can seek to understand how a sociocultural institution works in terms of its roles or tasks (Hempel, 2001). This process involves identifying the core functions of a group or organisation. Then these functions are used to form a 'map', and then key tasks are identified. However, functional analysis has been criticised as being 'overly reductionist' because there is too much focus on task, and on how tasks should be undertaken, to allow what has been described as the 'artistry' of health promotion (Mendoza, et al., 1994).

Drawing up a set of draft competencies is usually the next stage. This draft can also include a discussion paper as in New Zealand. Once this has been done the competencies can then be disseminated for consultation and feedback to as wide a range of practitioners in as many settings as possible. A variety of methods can be used for this part of the consultation. In Scotland, Australia and Canada the consultation process used questionnaires (Health Scotland, 2003; Howatt et al., 2000), while focus groups were used in the US (Gilmore et al., 2005), 'think tanks' were employed in New Zealand (McCracken et al., 2000) and workshops in ASPHER. The extent to which the procedure for these consultations and the resulting feedback is documented varies considerably and in many cases the findings were not systematically recorded and/or reported.

Consensus building using the Delphi technique is commonly used as evidenced in the competency sets developed in Australia and Canada (Howatt et al., 2000; Shilton et al., 2003, 2005; Hyndman, 2009). The Delphi method, is an attempt to obtain expert opinion and information in a systematic manner where participants are polled individually usually with a self-administered questionnaire (Fink et al., 1984). This is a multi-stage process where each stage builds on the results of the previous stage. The survey is conducted over a few rounds and after each one, the results are elicited, analysed and then reported back to the group. It is an iterative process with the aim of using expert opinion to reach consensus. A Delphi is considered complete when there is a convergence of opinion or when a point of diminishing returns is reached (Fink et al., 1984). The Delphi technique, although frequently used, has been criticised as it is suggested that it reduces competencies to a meaningless

‘middle ground’ and that the political aspects of health promotion can be lost in the ‘move towards the centre’ (Mendoza, 1994).

All consultations whether they are Delphi, think tanks or focus groups, will use multiple rounds of consultation to ensure the widest scope of feedback possible. The feedback from the consultation process is then analysed and this is used to prepare a final draft of the competencies which can then be disseminated and ratified. However, as Moloughney (2006) states, competency set development is an iterative process and it may be necessary to cycle through some of these steps a few times. Even when a ‘final’ draft set is produced, it is really only a working draft that will need to be periodically reviewed and revised as experience with the competencies accumulates and the field itself evolves.

It is generally agreed in the literature that competencies are more likely to be seen as appropriate and valid if they are developed from the ‘bottom up’ with the close involvement of the professionals who have to demonstrate competence on a daily basis in their work (Birt and Foldspang, 2009) and this approach was widely used in the frameworks reviewed. However, it can also be argued that, by basing competencies on practice as described and defined by practitioners, what is reflected is not necessarily ‘best’ or evidence-based practice but rather what is commonly ‘done’ (Battel-Kirk et al., 2009).

There are also limitations in using current practice (or what might be termed ‘past’ practice given that the development of competencies is a slow process) as the basis for competencies, particularly if they are to be used in future planning. Prastacos et al., (2005) for example, indicate that, in the business environment, competencies are often ‘backward-looking’ and recommend the use of a forward-looking development model which takes cognisance of the context and the current trends within which the organisation operates. A strategic approach that looks to the future as well as current practice when developing health promotion competencies (Shilton et al., 2001) and the importance of grounding competencies in current policy has also been highlighted (Health Scotland, 2003).

For this reason the development of agreed upon lists of competencies has to be the result of a repeated and continuing process, characterised by interaction between the main stakeholders across the academic, practice and policy areas. It is not a purely academic exercise, neither for that matter a purely practical or political endeavour, accordingly it is necessary to develop a strongly communicative culture, with consensus building processes in focus (Birt and Foldspang, 2009).

Meresman et al., (2004) recommend that competency development should be seen from an evolutionary perspective, and that competencies should be reviewed and revised regularly within their specific contexts. This was also recommended and formed part of the process in Australia and Canada where the current competencies have been reviewed and updated since their original inception. It is also recommended that a plan for reviewing the framework, including a timescale, is agreed as part of the development process (Centre for Health Policy, 2008).

This review demonstrated the many approaches that can be applied to the development of competency frameworks. A variety of approaches were used with no one method being

replicated exactly in other developments. However, there is agreement across the various studies that the core competencies should identify what is specific and unique to health promotion and should reflect the ethical, theoretical and research principles which underpin its practice. Therefore, the competency development process needs to be rigorous and inclusive, systematically undertaken and firmly grounded in the core principles and practice of health promotion. In developing European core competencies, it would appear based on this review that a 'multiple-method' approach, based on consultation with as wide a range of stakeholders as possible, is appropriate in order to capture the complexities of health promotion in the European context.

### **Critical Issues**

As this review illustrates, while there has been much interest and activity in developing competencies and standards for a wide range of work groups, including professionals, this approach has not been without its critics. In the literature on the use of competencies and standards<sup>55</sup> across a range of applications some common critical themes emerge. There are also some areas of difficulty recognised in relation to the development process, implementation and maintaining currency of competencies. The literature identifies controversy about the overall usefulness and appropriateness of defining competencies for health promotion and, for some; the negative impacts of what is perceived as an overly prescriptive approach outweigh the potential benefits. In the development of a seminal project such as CompHP it is important that the criticisms of the competency approach, and the lessons learned by others in developing and implementing the approach, be explored and used to guide the project to avoid known pitfalls and develop the best possible competencies framework.

The literature on health promotion competencies focuses mainly on the processes by which they were developed and on presenting the completed competency frameworks. There is also some discussion of the contexts which have influenced competency development, the value or otherwise of the competency approach in relation to health promotion, and their relation to professionalism and professionalisation. For example, Shilton et al., (2001) refer to 'pros and cons' in relation to competencies for health promotion and the possible negative areas of the approach they identify can be summarised as:

- Restricting/reductionist/mechanistic/ limiting innovation and therefore not allowing for the dynamic nature of health promotion
- Tending to undervalue professional judgement and experience

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<sup>55</sup> Some of the literature referenced refers to 'competency', 'competences' and also to standards. There is, as indicated by Bolden and Gosling, (2004) overlap and cross referencing between the terms in the literature and this is also the case for this discussion.

- Disregarding values and principles.

Mendoza et al., (1994) identify a tendency for the use of competencies to lead towards 'universalism' where practice is seen as being mono-dimensional and competencies are viewed as covering all aspects, levels and contexts where health promotion is practiced. Hills and O'Neill (2003) report on a symposium which was held in the early stages of the debate on developing competencies in Canada and list the following as potential disadvantages and difficulties:

- How to identify competencies if there is no formally recognised professional body of health promoters?
- If such a professional body exists, there is a danger to exclude others who have developed competencies and to threaten multidisciplinary
- Deciding on specific competencies may slow down the development of new practices in a field that is still young
- The processes to identify the competencies are very time consuming and complex, as well as the translation of the competencies, once identified, in courses and programmes
- Such exercises may expose the profession to external control and judgement
- It might create a dilemma about health promotion being a field in itself or just part of another field, potentially weakening its legitimacy
- For some, the values of health promotion that are participatory seem incompatible with the normative approach of a competency-based approach
- The threat that such an approach limits the practitioners' freedom of intervention
- The perception that it is reductionist, that it excludes other approaches
- The possibility it makes more difficult to keep the broader picture in mind.

Hills and O'Neill (2003) also express concern that the exercise of developing competencies may expose the developing health promotion profession to external control and judgement and may create a dilemma about health promotion being a field in itself or just part of another field, potentially weakening its legitimacy.

Many of these issues, together with a number of others, are also discussed as potentially negative aspects of the competency approach in the literature from other disciplines and professional groups (for example, Reeves et al., 2009; Talbot, 2004; Miller et al., 2010; and Hughes, 2005). The benefits and disadvantages of the competency based approach, while discussed specifically in relation to training and in the context of public health nutrition, are well summarised by Hughes (2005). The arguments in favour of competency based training are:

- Role clarity and delineation – competency based standards aim to define the work and performance of the profession and therefore help define and delineate roles. Preventing overlap between professions may improve efficiency and this has been a compelling argument in favour of competencies

- Accountability and credibility – standards help define the nature of the work of a profession and help communicate the complexity of work which may increase the credibility of the profession amongst the community
- Education – Competencies provide clearer roles for educators, learners and assist with curriculum testing and assessment
- Consistency – competencies can assist universities produce graduates with consistent minimum competencies because they provide a common ground for discussion between teachers and the profession
- Equity – Competency measurement can increase equity between people from different backgrounds, i.e. assessed based on ability to perform rather than academic path or course completed
- Cross profession movement – The common language of competencies that are consistent between professions can enable transfer across disciplines or overseas recognition.

Hughes (2005) also outlined the arguments against competency based training:

- Reductionism – the tendency of competencies and competency assessment to isolate components of performance ignores the complexity of work
- Efficiency does not mean effectiveness – A more competent worker does not necessarily lead to a more effective worker
- Control and sameness - Competencies and the use of competencies as a basis of credentialing can constrain workforce construction and behaviour leading to lack of innovation and diversity
- Checklists – competency assessment can become complicated leading to a simplistic use of competencies as checklists. Skills performance without knowledge and context can be life threatening in the health sector
- Towards mediocrity – competencies prescribe minimum standards that might discourage excellence by reducing everything to the lowest common denominator
- Teaching to the test – Competencies may encourage a belief that something that is not measurable as a competency it is not worth doing or learning and threatens the learning processes
- Questionable reliability – There is no evidence to support CBT as a reliable measure
- Reduced liberal education – The tendency of competencies to be reductionist may reduce elements of liberal education such as experimentation, attributes the learning how to learn and problem solving.

The Chartered Institute of Personnel and Development in the UK (CIPD)<sup>56</sup>. Competencies toolkit lists the following as the common criticisms of competency frameworks:

- They capture the past and are therefore out of date
- They cannot keep up to date with the fast changing world
- They were introduced to improve performance and they have not done so
- They are unwieldy and not user friendly
- They create clones; everyone is expected to behave in the same way.

The publication while acknowledging the validity of these criticisms, also notes that they have been levelled with justification mainly at frameworks produced using poor practice and highlights the need for care and understanding when developing and implementing competency frameworks. It is important, therefore, that the development process for the health promotion competencies being undertaken by the CompHP project, explore in some depth the criticisms levelled at the approach and be informed by these to ensure the best possible process and outcome.

A major criticism of the competency approach, particularly in relation to professional practice, which has already been noted in relation to health promotion (Shilton, 2001) is that it may be overly prescriptive and can, therefore, limit intuition, creativity and innovation. This has been particularly argued in relation to complex areas of practice (as is the case in health promotion). For example, Talbot (2004) suggests that the competencies approach has a tendency to limit the reflection, intuition, experience and higher order competence necessary for expert, holistic or well developed practice. Hills and O'Neill (2003) quote practitioners attending a symposium in Canada in 2003 as concluding that health promotion competencies could be useful if they were broadly defined and treated as guidelines. At the same time the practitioners expressed significant concern that limiting or rigid uses of competencies as professional standards could easily be detrimental for health promotion (Hills and O'Neill, 2003). This was further reflected in another Canadian commentary on the gains and risks of professionalising health promotion Ontario Prevention Clearing House (OPC, 2006) which stated that: *"The task is to ensure that competencies add to the practice of health promotion, rather than narrow or diminish its practice"* and *"while the Ontario Prevention Clearing House<sup>57</sup> welcomes competencies, we will strive to be sure that these competencies are guidelines to inform practice, not prescriptions to limit practice"*.

The tendency within the competency approach to focus on measurable behaviours and outcomes and not on other qualities, situational interactions and contextual factors is argued as likely to limit attention to, and importance of, values, beliefs and relationships (Bell et al., 2002). This again has particular resonance for health promotion which, it has been claimed, can be considered an 'ethical endeavour' and which is in its essence concerned with context and settings. It has been suggested that it would be impossible to capture its true essence in the confines of a competencies

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<sup>56</sup> <http://www.cipd.co.uk/>

<sup>57</sup> The Ontario Prevention Clearinghouse (OPC) is an incorporated non-profit organization. Launched in 1985, recognized as health promotion leaders. <http://www.ohpe.ca/node/4765>

framework. For some, the values of health promotion that are participatory seem incompatible with the normative approach of a competency-based approach (Hills and O'Neill, 2003).

Talbot (2004) also argues that a reductionist tendency, which focuses on tasks and outcomes inherent in the approach, ignores the complex processes needed for professional practice. Lester notes that this approach has been extensively criticised for weaknesses in its ability to represent occupations which are characterised by a high degree of uncertainty, unpredictability and discretion, and its tendency to atomise work roles rather than represent them holistically (Lester, 1994). Hills and O'Neill (2003) suggests that deciding on specific competencies may slow down the development of new practices in a field that is still young. These points are relevant for the CompHP project as in health promotion the emphasis is on holistic approaches and practice occurs in complex and other uncertain settings.

Many professional groups have debated these issues, and, for example, teacher educators have highlighted the fact that a narrow conceptualisation of teaching which is associated with a narrow competency approach is not applicable to the complexity of their setting (Danielson 1996). There are recommendations across all disciplines on the need to avoid developing overly prescriptive definitions of competency that may unintentionally limit the professional autonomy and decision-making ability of the individual practitioner. This warning has been heeded in the early stages of the competencies development process of the CompHP project and will be a topic for discussion in consultations with practitioners at later stages in the process.

The competency approach has also been criticised as being 'overly universalistic' (Bolden and Gosling 2004; Mendoza et al., 1994). There is discussion in the literature of the fact that there can be an assumption that competencies and standards are equally relevant to all practitioners in all settings and situations, an assumption that is, it is suggested, obviously incorrect. This again has resonance for health promotion, which is practiced at different levels, by people from different backgrounds and in a wide variety of settings. The concept of equifinality (Bertalanffy, 1968), which argues that there can be many different and valid origins for a given outcome, can be related to the context of practice, meaning that many different behaviours on the part of the practitioner may lead to competent outcomes. This broader interpretation of competencies should inform both the development and the implementation of competencies. The challenge of establishing competency frameworks, therefore, includes addressing the complexity of practice in a manner which is meaningful and clear while also leaving room for the many varied paths possible in successful practice. The problem with very detailed frameworks is that they tend to be difficult and unwieldy to use. On the other hand, competencies which merely general statements have been criticised as not providing enough substance and being open to wide divergence of interpretation (Battel-Kirk et al., 2009). There is a need, therefore, to consider how core competencies will be expressed to be meaningful, useable, relevant and succinct. *"What is needed is a set of commonalities underlying the actions, with the recognition that specific actions will and should vary depending on the context of practice"* Miller et al., 2010).

These arguments have been made across a wide range of professions and applications of the competency approach, for example, in relation to medical education in the UK where a concentration on the competency approach has, it is argued, a tendency to limit the reflection, intuition, experience and higher order competence necessary for expert, holistic and well developed practice (Talbot, 2004).

The competency approach may also, it has been suggested, reinforce, rather than challenge, traditional ways of thinking about practice (Lester, 1994, Reeves et al., 2009). Meresman et al., (2003) suggest that establishing an 'officially agreed' interpretation of health promotion practice based competencies could discourage diversity and creativity. The codification of what is considered good or 'best practice' as defined by current practitioners may be used to justify maintaining the status quo as challenges to the established system can be refuted by reference to 'validated' competencies and standards. Not only may there be a resistance to change because of fear or conservatism but there are costs (both monetary and time) in revising and redeveloping competency frameworks which may reinforce the reluctance to change the status quo.

The conception, design and implementation of competency frameworks and tools are, it is suggested, also worthy of questioning in relation to maintaining the status quo. Typically, competency-based approaches are created through a combination of quantitative and qualitative methods by professional experts who define what the elements of 'competent' professional practice should be. The result of this process is that the competencies drafted reflect their particular views of what constitutes 'best practice' at the point in time they were created (Carraccio et al., 2002). Reeves et al., (2009) note that even when the development of competencies involves large samples of practitioners, they are usually required to rate or comment on a pre-determined menu of best practice options. These options are usually created by professional experts and leaders which, while their input may convey a sense of legitimacy and rigour, it can be argued that this process reflects and reinforces the current thinking of a 'limited few' who occupy dominant positions in a professional group. As a result, competency-based approaches can be seen as versions of the collective views of the professional elites who have generated them (Wright Mills, 2000). Competencies have, therefore, been criticised as potentially reinforcing conventional discourses about professional norms, behaviours and attitudes, and perpetuating existing domains of professional legitimacy (Reeves et al., 2009).

Questions can also arise, particularly in a contested area such as health promotion, as to who are the 'experts' and what remit they have (or who appointed them) to be the voice of authority in the development process (Battel-Kirk et al., 2009). A further difficulty is that once competency frameworks are adopted and implemented, there appear to be few mechanisms available to support the introduction of new and innovative ideas that offer contrasting perspectives for practice. It is also suggested that, by basing competencies on practice as described and redefined by practitioners what is reflected is not necessarily 'best' or evidence based practice- rather a reflection of what is done – not what is best to do. Linked to this is the fact that while competencies are sometimes referred to as drawing on theory, no methodology has



been identified which links competency development to the evidence base. The inclusion of 'experts' and academics in the development stages could possibly address this concern but there is no evidence of weighting of comments based on researched evidence of good practice being formally incorporated into competency development (Battel-Kirk et al., 2009).

The possibility of competencies being used as a means of bureaucratic and political control is identified as a possible area of concern (Shilton et al., 2001) but point out that in Australia, however, where there was an established and specialist health promotion workforce, supported by a professional association affiliated with IUHPE, competencies were developed within a strong professional context not overly influenced by external forces. It is evident, however, that, as with every aspect of health promotion, the political and social contexts will influence if, and how, competencies are developed, how they are used, by whom and to what end. The value in developing internationally agreed core competencies, validated by leading authorities in the field and by recognised organisations such as IUHPE, SOPHE etc. is that these will become a reference point for all, from whatever context or opinion, to consider in relation to health promotion practice, education and research.

The focus in the development process on current 'best practice' also means that competencies can date quickly and have, therefore, been described as being equivalent to 'driving using the rear view mirror' (Cullen, 1992). There is recognition in the literature of the limitations of using current, and indeed what might be termed 'past' practice given that the development process usually takes at least months before competencies are published (Battel-Kirk et al., 2009). In 1996 recommendations were made for a more strategic approach that looked at future as well as current health promotion practice when defining competencies (Shilton et al., 2001). Meresman et al., (2003) recommend that competency development should be seen from an evolutionary perspective and that discussion on their definition should be revisited regularly and in the specific contexts where they are used in practice.

Prastacos et al., (2005) indicate that a central issue of concern in the development of competencies in the business environment is that they most often end up being 'backward-looking' and recommend that a forward-looking model for developing competencies should include:

- The context and the current trends in the industry where the organisation operates
- Competencies structured in a way that makes it easy to delete outdated competencies, and integrate new ones.

Thus, it is argued that competencies and standards can hinder rather than encourage an ongoing review and consideration of how practice is conceived and applied, especially with regards to those aspects of the job that are prone to change. Reference is made to this being particularly the case in relation to the impact of new technologies and globalisation. This again has particular relevance for health promotion given the constantly changing environments which impact upon it – including globalisation and its local effects. Follow on criticisms from this 'backward looking' problem is that while

competency frameworks have been promoted as a key tool for workforce planning, the frameworks are in fact not geared towards such forward planning (Battel-Kirk et al., 2009). In addition to non-specific suggestions that competencies need to be updated other bodies, such as the Centre for Health Policy (2008) recommend that the process for review and updating should involve description of current practice to identify new or variations in competencies, together with expert consultation regarding the latest view of practice. Many also suggest the optimal interval for updating as within five years of publication and also recommend that the timeline for revision be identified when the competency set is developed.

There is also discussion in the literature in relation to the difference and importance of expertise versus mere competence. Dreyfus and Dreyfus (1986) for example, identified a five-step process by which humans move from novice to expert in any domain of occupation. These five steps include (a) novice, (b) advanced beginner, (c) competent, (d) proficient, and finally (e) expert. In Leithwood's (1992) model, developed in the context of teacher training, the trainee /developing professional moves through six stages from (a) developing survival skills, (b) becoming competent in basic skills, (c) expanding flexibility, (d) acquiring expertise, (e) contributing to the growth of colleagues' expertise, and (f) participating in a broader array of decisions at all levels. Instead of focusing only on what counts as 'competent practice', some have advocated that professions should strive for expertise as the final goal in professional development and it has been argued that competencies and standards should be focused to the development of expertise versus mere competence.

There have been some attempts to marry competency frameworks for health promotion and levels of expertise (e.g. New Zealand Health Promotion Forum 2000, 2004 and Health Scotland 2003, 2005) but these are in the minority. There can be difficulties in relating competencies neatly into levels of expertise as there will be significant overlap and the levels can be difficult to express, agree and measure. Other disciplines do, however, incorporate levels of expertise into their competency frameworks while others address this in professional standards. The issue of expertise and how it relates to the pan European competencies to be developed by the CompHP Project will need to be further explored in the later stages of the project when the overall framework is mapped against academic courses and is also tested in practice settings.

Difficulties in developing, maintaining and using competencies have also been noted. The development process can be complex and time (and other resource) consuming. In a description of the development process Miller et al., (2010) describes a common path followed by professional groups and list the final point in the process as 'struggling under the enormity and complexity of the task'. Hills and O'Neill (2003) raised concerns about the fact that the processes to identify the competencies are very time consuming and complex, as well as the translation of the competencies, once identified, in courses and programmes. The costs of the initial development process and updating procedures are of particular relevance in the current economic climate which has led to cuts in many aspects of health care, not least in the non-acute sector.

Another difficulty, already discussed in this report, is that there is no one agreed method of developing competencies and all methods that have been used are open to criticism. For example, the consensus building process used frequently in developing competencies has been criticised as it is suggested through this process competencies are reduced to a 'meaningless middle ground' and that the political aspects of health promotion, in particular advocacy and empowerment, may be lost in the 'move towards the centre' (Mendoza et al., 1994). It is also argued that the repeated redefining of words and concepts in response to feedback results in language that is meaningless and overly simplistic.

There is also debate in the literature about the level of detail required to enable, rather than stifle effective practice. The problem with very detailed frameworks is that they tend to be difficult and unwieldy to use (as was the case in the UK). On the other hand, competencies which merely general statements have been criticised as not providing enough substance and being open to wide divergence of interpretation. There is a need, therefore, to consider how core competencies will be expressed to be meaningful, useable, relevant and succinct.

While most development models build on consultation and varying degrees of consensus there is an inherent difficulty in attempting to formulate competencies which all professionals in a specific groups will agree with. This is particularly the case for health promotion which is still considered a 'contested concept', and is practiced and taught in different ways across Europe. This situation is echoed by Miller et al., (2010) in relation to marriage and family therapy where it is noted that that developing a clear set of competencies is daunting in light of the many conflicting philosophical values within that field. It is also noted that the development of competencies is particularly challenging given their field's historical resistance to codified, standardised approaches that may resemble the modernist and diagnostic style of other clinical disciplines – again reflecting many dissenting voices from the health promotion field, for example the opinion that as health promotion practice matures and grows, practitioners continue to struggle with issues of identity, seek consensus around who we are and what we do, and debate the pros and cons of particular approaches and philosophies (OHP, 2004).

There have been criticisms of the competency approach in relation to professional education in that it is considered to lead to a limited and mechanistic approach with a focus on training rather than education. Brundrett, (2000) stressed the differences between training and education with the former described as aiming to impart knowledge, skills and attitudes necessary to perform job-related tasks and to improve job performance in a direct way while education is defined as *"a process whose prime purpose is to impart knowledge and develop cognitive abilities"*. The limitations of training 'fit for purpose' practitioners have been linked to the growing emphasis on competency approaches. Questions arising from this philosophy of education include who is defining what 'fit' means, and perhaps more importantly what is the 'purpose'. In health promotion the 'purpose' is often a contentious issue with employers often focusing on health education and lifestyle change rather than the socioecological concepts of health promotion as defined in the Ottawa Charter (World Health

Organisation, 1986). Who defines competencies and what approach to developing and maintain practitioners' knowledge is, therefore, key to the continuation of a workforce for health promotion which is based on ethical concepts and the tenets of the Ottawa Charter. These concerns can be linked to the earlier discussion on the potential for competencies to be used as a means of political and bureaucratic control.

Differences in the degree of acceptance of competencies as the basis for pedagogical endeavours is evident in the literature. For example, Talbot et al., (2007) state that competency standards offer benefits for curriculum and assessment development and are a powerful guide to providers of professional education. Others consider that there is a risk that competencies may be used as a 'checklist' of behavioural tasks (Mendoza et al., 1994) and that that competencies frameworks may lead to a 'single model of vocational education' across all educational settings. This argument is dismissed by Talbot et al., (2007) who propose that, when competencies are used as a global guide, they provide an appropriate and useful benchmark for curriculum planners for health promotion education. This viewpoint is endorsed in a useful 'toolkit' for using competencies in curriculum development for public health education (Centre for Health Policy, 2008) which states that no listing of competency statements automatically becomes a curriculum. It is suggested that the desired competencies must be re-stated, and sometimes broken into smaller units, or arranged in different order when constructing a well-structured curriculum.

The many challenges faced by one discipline in the pursuit of core competencies will likely be faced by all other - even dissimilar - disciplines. In the same way, although discipline-specific competencies differ, the mechanisms that aid in the development of competencies appear to be quite similar across disciplines. The creation of competencies may also be regarded as an effort by professions to define certain activities that 'belong' to them (Reeves et al., 2009). This is suggested to be particularly relevant in health care where resources are limited and professions seek to demonstrate their unique roles in order to secure and legitimise their places on health teams. An example is given of a professional conflict over scope of practice for providing breastfeeding support to new mothers. Both nurses and the nutritionists felt they were the 'experts' in this area and debated who should provide the service. The issue was resolved by reviewing professional competencies for each profession and assigning specific roles. The nutritionists were deemed to know best about the composition of breast milk and alternatives, while the nurses were given jurisdiction over how to position the infant, foster a proper latch, and provide overall breast health guidance. Thus, the nutritionists became the profession 'allowed' to discuss the nutritional value of breast milk, while the nurses had exclusive rights to breastfeeding positioning. Both agreed to withdraw from the other's 'area of expertise'. The authors conclude that 'the maternal breast and the act of breastfeeding were essentially carved up according to professional competencies, with little or no regard for the expertise of the mother herself, or the other professions who support breastfeeding in the community such as midwives and lactation consultants, Reeves et al., 2009). Situations such as this raise questions about the impact of competencies on

collaborative practice which is a lynch pin of health promotion, especially where profession-specific domains of practice overlap.

While the development of competency frameworks may help define professional scopes of practice and differentiate the roles of one profession from another, as the example above indicates, competency domains can often overlap. As health promotion is premised on multidisciplinary partnerships and many professional groups lay claim to being 'health promoters' the lines of demarcation are difficult to discern. In light of the above example this may be a positive consideration. In discussing the development of health promotion competencies and in some of the developed frameworks, claims are made that their purpose is not to be exclusionary (e.g. New Zealand Health Promotion Forum, 2000; Hyndman, 2007). In a discussion paper on the development of competencies in Canada Hyndman (2007) reports that, 'the proposed competencies are meant to inform health promotion practice, not to limit or exclude, and by extension, strengthen the practice and field'. This inclusive approach could be said to contrast with the definition of core competencies being 'rare' and difficult to imitate and other professions use competencies to identify, define and protect professional boundaries. The dilemma is, therefore, that either the health competencies are for all who 'promote health or they are claimed by a 'specialist' group to delineate professional boundaries. The overall impression from the literature is that there is concern about the potentially negative aspects of rigid professional boundaries on health promotion which, by its very definition, claims to be participative and empowering.

There is also the question of overlap between different 'competencies' covering the same area – for example currently the Association of Schools for Public Health Education ASPHER is developing competencies for public health which contain a subsection on health promotion. Other professions, for example nursing, often include health promotion within their profession specific competencies. Reeves et al., (2009) state that a cursory examination of a sample of current professional competency frameworks (e.g., Canadian Nurses Association, 2005, the Australian Association of Occupational Therapists, 2009, National Center for Gerontological Social Work Education, 2009) reveals similar competency categories and statements in areas such as communication, assessment, planning, monitoring and advocacy. To this list can be added various health promotion competency frameworks, such as in Australia (AHPA, 2009), New Zealand (New Zealand Health Promotion Forum, 2000) and the National Occupational Standards in the UK. There is, therefore, a question as to how much of these competency-based approaches, which set out to define unique areas of practice end up simply re-inventing slightly different wheels as suggested by Reeves et al., (2009). To deal with these complexities Reeves et al., (2009) suggest the following:

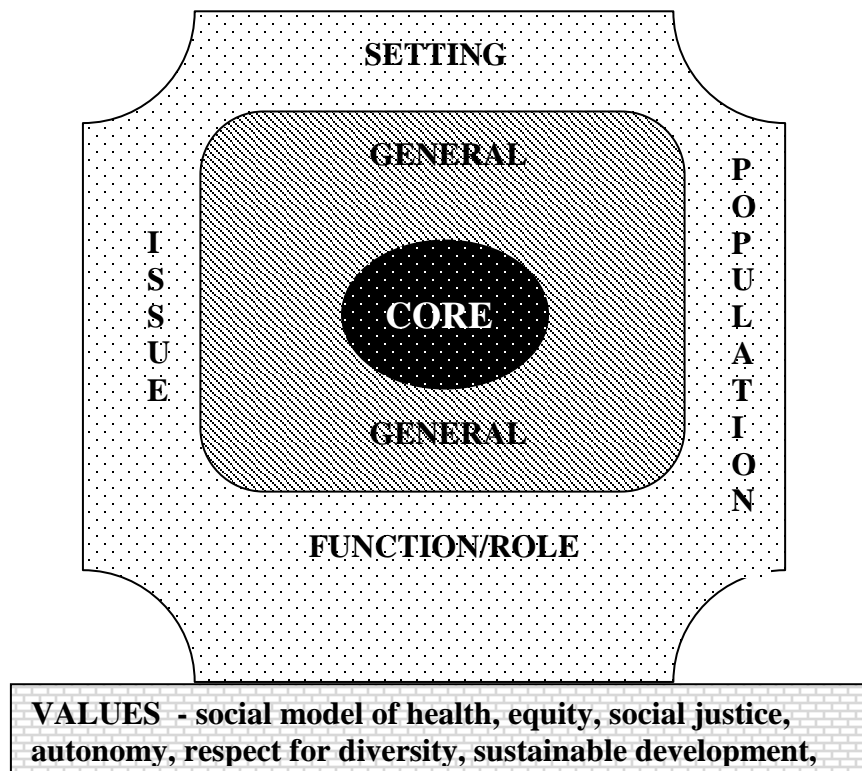
- The need to both challenge and streamline processes that essentially bring about the same core skills in many different professions
- Research could be undertaken to compare competencies across professions to see what gets categorised as 'unique' to each group and what is regarded as 'common'
- Explore the impact of competency implementation on interprofessional practice, as the underlying assumption appears to be that by clearly defining

each other's roles practitioners will have a firmer understanding of how to work together.

This debate also raises questions as to what should be included as 'core competencies' for health promotion. Coyne et al., (1997) proposed that a core competence 'is a combination of complementary skills and knowledge bases embedded in a group or team that results in the ability to execute one or more critical processes to a world class standard.' The characteristics of core competencies are that they: provide a set of unifying principles for the organisation, are pervasive in all strategies/markets and are rare and/or difficult to imitate. (Prahalad and Hamel, 1990). There are differences in the literature as to what actually constitutes 'core' competencies'. In its truest sense it could be argued that they refer only to those aspects of practice that are 'core' to health promotion rather than competencies that may be required (e.g. management, communication, etc.) for effective practice but which are common across a wide range of disciplines. The term 'core' is used only in the Australian health promotion competency framework (Shilton et al., 2001, 2007).

The following model, based loosely on Moloughney (2004) is suggested to explain the relationship between core and other competencies.

**Figure 3 - Title (adapted from Moloughney, (2004))**



- Core health promotion competencies - reflect the common understanding and set of skills, knowledge and abilities that characterise the health promotion approach to health issues
- General competencies – are those required for effective health promotion practice but which are also common to other professions, disciplines and activities
- Function/ role, issues, setting, population based competencies relate to the specific function or role, issue, setting or population within which the practitioner operates. Competency sets may already be specified for these roles.

This model allows for flexibility in considering the roles of health promotion 'specialists' and the matching of core health promotion and other competencies for those whose role is only partly in this field.

Core competencies for health promotion at international levels, it is therefore suggested, are those which specifically support practice, education and research to undertake the five key areas of the Ottawa Charter through the activities of enabling, advocacy and mediation. Whatever the specific combination of competencies agreed as appropriate for a given professional group, the key test is how they are

implemented and what effect they have on practice and ultimately the target of that practice – in the case of health promotion the promotion of population health. Some competency frameworks have been developed but, due to changes in the political and professional contexts, have not been widely used. This was the case in relation to the National Standards for Professional Activity in Health Promotion and Care in the UK (Care Sector Consortium, 1997) which after extensive piloting, ceased to be used, mainly due changes in the health training sector, coupled with the fact that the findings of the pilot projects were considered inconclusive (Health Scotland, 2003) and the move to ‘multidisciplinary public health’ which subsumed disciplines involved in health improvement including health promotion. The development process must, therefore, in as far as possible, take into account the wider political and social environment which may impact on the use (or non-use) of the competencies. While there is not, as yet, a large body of research on the impact of competencies in the medium and longer terms, the approach continues to be supported by professional associations, authoritative non-governmental organisation such as the World Health Organisation and the International Union of Health Promotion and Education (who are key partners in the CompHP project) and Europe wide and national bodies as evidenced by the fact that the European Agency for Health and Consumers funded the CompHP, the support for the project from partner organisations and departments and its ongoing use in many countries, disciplines and settings.

The criticisms of the competencies approach do not, however, negate its positive contributions which have been discussed elsewhere in this document. Both when developing and reviewing competencies, on an ongoing basis, there is a need for more critical debate about the purpose, ways and the degree to which competencies are used to shape education, regulation and practice. While the clear definitions of scope of practice and performance indicators which competencies provide are important contributions to health promotion practice, their development and use should also take cognisance of the potential constraints they impose and the conflicts they may provoke. Ongoing dialogue, openness to criticisms and support for innovation should, therefore, be part of any attempt to develop and implement the competencies approach in health promotion.

It is important when considering the potentially negative aspects of the competency approach and the difficulties in the development, implementation and revision process to view this in balance with the many listed positive aspects of competencies which include (based on Shilton et al., 2001):

- Usefulness as a shared/agreed language for defining boundaries of profession and the tasks, skills and knowledge required for adequate practice
- Helpfulness in developing programmes and projects, curriculum development and in recruitment and selection
- Contribution to defining/defending discipline.

Hyndman (2007) lists the key reasons for health promoters to identify discipline-specific competencies (and by implication their benefits) as follows:

- To inform and structure the content of health promotion training programmes



- To assist in the development of competency-based job descriptions for health promoters
- To inform the development of health promotion training needs and assessment tools
- To inform curriculum development of continuing education for health promoters
- To increase understanding of the range of knowledge and skills required by health promoters to effectively plan, deliver, and evaluate health promotion initiatives.

Overall benefits, which have been identified as accruing from the development of public health competencies, can equally be argued to apply to competencies for health promotion.

Based on the recommendations of the Ontario Public Health Association and the Public Health Agency of Canada, health promotion competencies can be argued to potentially improve the health of the public by:

- Contributing to a more effective workforce
- Encouraging service delivery that is evidence based, population-focused, ethical, equitable, standardised and client-centred
- Helping to create a more unified workforce by providing a shared understanding of key concepts and practices.

Clearly identified core competencies can also assist health promotion organisations to:

- Identify the knowledge, skills and attitudes required across an organisation or programme to fulfil health promotion functions
- Identify the appropriate numbers and mix of health promotion workers in a given setting
- Identify staff development and training needs
- Provide a rationale for securing funds to support workforce development
- Develop job descriptions, interview questions and frameworks for evaluation and quality assurance
- Facilitate collaboration, shared goals and interdisciplinary work.

Competencies can also benefit the people who work in health promotion by:

- Providing guidelines for the basic knowledge, skills and attitudes required by individual practitioners in health promotion
- Supporting the recruitment, development and retention of health promotion practitioners
- Providing a rational basis for developing curricula, training and professional development tools
- Improving consistency in job descriptions and performance assessment
- Helping to explain the nature of health promotion and health promotion goals.

## Addressing the Issue of Professionalisation

In the literature reviewed, and to a much greater extent within the health promotion community, reference to the development of competencies leads to debate on the relationship of their development to professionalisation<sup>58</sup> (e.g. New Zealand Health Promotion Forum 2004; O'Neill 2003; Hyndman 2007; Ontario Prevention Clearing House (OPC)<sup>59</sup> 2006). Some of the debate on using 'core competencies' has centred on health promotion professionalisation and accreditation<sup>60</sup> with concern expressed that exclusionary practices can arise, and the limiting of a multidisciplinary field that is constantly evolving (OHP, 2004). The key questions in this debate are whether, in fact, health promotion is a profession, if it is not whether it should be and what moves, if any should be made to develop registration/accreditation systems which exert professional control over who is accepted to be a health promotion professional and how they practice. This debate, together with the fact that a commonly identified use of competencies is the delineation of professional boundaries and that their usefulness has been linked to specific 'professional issues' for example levels of pay (OPC 2006, Hyndman, 2007), make it necessary to make some reference to the contentious subject of professionalisation in any discussion on competencies development.

Diversity in health promotion has long been recognised as a key strength of health promotion practice and the opinion that health promotion is best performed by individuals with a wide variety of training and backgrounds and that it would be detrimental for health promotion to be delivered by one professional group to the exclusion of others is widely held. This diversity has been credited with ensuring openness to a broad spectrum of people within community organisations, agencies, social, educational and health services and institutions, as well as the public and private sectors at provincial and national levels being active in health promotion. It is also surmised that this further generates openness to include individuals from diverse communities and cultures (OPC, 2006). The diversity in health promotion includes not only a miscellany of backgrounds of practitioners but differences in models of health promotion with associated differences in approach and practice and wide variety in the requirements (if any) to enter practice as a health promoter. While diversity can be a strengthening factor, particularly in health promotion which focuses on collaboration and multidisciplinary, there are significant challenges associated with the multiple backgrounds and skill sets of health promoters including the false impression that anyone can practice health promotion (Hyndman, 2007). There is, in addition, the

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<sup>58</sup> **Professionalisation** is the process by which any trade or occupation transforms itself into a profession. This process usually involves establishing acceptable qualifications, a professional body to oversee the conduct of members of the profession and demarcation of the qualified professional from others by means of a registration/accreditation/credentialing.

<sup>59</sup> The Ontario Prevention Clearinghouse was Ontario's leading bilingual health promotion organization. In April 2008, the Ontario Prevention Clearinghouse became Health Nexus -- and in French, Nexus Santé. See [www.healthnexus.ca](http://www.healthnexus.ca) and [www.nexusante.ca](http://www.nexusante.ca)

<sup>60</sup> **Accreditation – professional/ individual:** a form of qualification or individual registration awarded by a professional or regulatory body that confirms an individual as fit to practise. The effect of accreditation will vary depending on the market and regulatory context, ranging from being viewed as being essential or almost essential for gaining work in a profession, providing access to a greater range of work and to higher levels of remuneration; or have little effect. Based on Lester, S. (2005) [www.sld.demon.co.uk/accred.pdf](http://www.sld.demon.co.uk/accred.pdf). Definition agreed for CompHP Project Glossary

fact that there is difference and diversity across countries and regions in relation to the existence of a specific job title or role of health promotion together with an associated career path. Thus in some countries in Europe there are practitioners whose role is mainly, if not totally, health promotion. In some countries these practitioners are termed 'specialists' although this is not universally accepted as the term is the preserve of the medical profession in some countries. For other practitioners, health promotion is only part of their role and the percentage focused on health promotion can vary significantly (Santa-María Morales and Barry, 2007). This group is sometimes referred to in the literature as 'generalists'. One of the dilemmas in developing competencies for health promotion is deciding who the target audience is. If, for example, they are developed for the generalists it could be argued that this may be seen to dilute the concept of health promotion as a specific area of practice and may have negative impact on the status, levels of employment and pay for health promotion 'specialists'.

In any discussion of professionalisation for health promotion the first question must be 'is health promotion in fact a profession?' Health promotion is often referred to as a profession and many of the courses offered in academic institutions across Europe refer to 'professional practice' and professional practitioners. There are professional associations for health promotion practitioners in Europe (e.g. Association for Health Promotion, Ireland<sup>61</sup> and NVGP in the Netherlands<sup>62</sup>).

The claim that health promotion does constitute a profession can be tested by referring to definitions of a profession. This again raises complexities and debate as there is no universally agreed definition of what constitutes a profession and this has changed over time. Clouston and Whitcombe (2008) in discussing the professionalisation of occupational therapy state: 'Professions are socially constructed phenomena. Accordingly, an understanding of what is meant by a profession, with its associated social positioning and how that is interpreted, is governed by historical, temporal, cultural and ideological influences.' They conclude that for occupational therapy, such an understanding can be a real challenge, and this is no less the case for health promotion. It is further suggested that in the current political and economic climate professions now have to prove added value and to adapt to organisational and bureaucratic realities, moving from professional defined by 'status' or common attributes to professions defined and controlled by employing organisations (Noordegraaf, 2007).

A definition offered by Professions Australia<sup>63</sup> a national organisation of professional associations which aims to advance and promote professionalism for the benefit of the community includes many of the attributes identified as defining a profession: "*A profession is a disciplined group of individuals who adhere to ethical standards and who hold themselves out as, and are accepted by the public as, possessing special knowledge and skills in a widely recognised body of learning derived from research,*

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<sup>61</sup> <http://www.ahpi.ie>

<sup>62</sup> <http://www.nvpg.net/>

<sup>63</sup> <http://www.professions.com.au/defineprofession.html>

*education and training at a high level, and who are prepared to apply this knowledge and exercise these skills in the interest of others. It is inherent in the definition of a profession that a code of ethics governs the activities of each profession. Such codes require behaviour and practice beyond the personal moral obligations of an individual. They define and demand high standards of behaviour in respect to the services provided to the public and in dealing with professional colleagues. Further, these codes are enforced by the profession and are acknowledged and accepted by the community”.*

The key elements of this definition are reflected in an article which attempts to define the term profession in the context of medical education where profession is seen as an occupation whose core element is work based upon the mastery of a complex body of knowledge and skills. It is a vocation in which knowledge of some department of science or learning or the practice of an art founded upon it is used in the service of others. Its members are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation. Professions and their members are accountable to those served and to society (Cruess et al., 2004).

While this definition is for an established and, in almost all countries, a professional defined and regulated by law, it reflects other authors' inclusion of a common code of ethics and control, if not monopoly, over entrance into and practice of the profession. This control is at the core of the ongoing debate about the professionalisation of health promotion. Thus, it is referred to as a profession, even by those who oppose regulation and professionalisation. It has also been claimed that it is irrelevant whether a group is defined as a profession but that its practitioners behave in a professional manner (Pajo and Cleland, 1997).

In health promotion, for example, there is no one body tasked with controlling professional activity in the majority of countries, and as noted, no formally recognised requirement for entry to practice or maintenance of knowledge and skills as is required by regulated profession such as medicine, law, nursing etc. There is also no universally agreed code of conduct or ethics. It could be argued that health promotion is an ethical endeavour and that the tenets of the Ottawa Charter are the ethical principles which guide practice. This differs, however, from the usual situation where a profession has an agreed, specific code of conduct, at least within national associations if not at wider levels. A reference is made in the recently developed 'Core Competencies for Health Promotion Practitioners' (Australian Health Promotion Association, 2009) to the future development of a code of practice based on the American Public Health Leadership Society's Principles of Ethical Practice of Public Health.<sup>64</sup> The UK based Society for Health Promotion and Education (SHEPS) developed a code of conduct for health promotion practitioners but, as previously

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<sup>64</sup> See <http://www.phls.org/home/section/3-26/>

mentioned this society is no longer active on a UK wide basis. However, SHEPS Cymru (the Society of Health Education and Promotion Specialists in Wales) and the Shaping the Future Collaboration<sup>65</sup> have worked together to develop this framework based on the earlier code<sup>66</sup>. The debate about an agreed code of ethics is an ongoing area of contention in the health promotion community<sup>67</sup>.

The debate about how health promotion should be structured (or restructured) into a profession with formal attributes of controlled entry and practice has been ongoing since its inception. It is interesting to note that health promotion emerged at a period when the relevance and ethical acceptability of professions and professional power was being questioned (Starr, 2009). From the 1960s onwards the so called 'learned' professions such as medicine and law were being challenged as overly exclusive, self serving and powerful. Other fields, such as social work, were struggling to come to terms with the dissonance between their participatory and empowering principles and the concept of professionalisation with its association with exclusiveness and dominance. Banks (2004), for example identified among other attributes of the contemporary social professions:

- a) An ambivalence towards professionalisation
- b) 'Deprofessionalising' trends (challenge to discretion and autonomy).

Banks continued by stating that there is 'an identifiable strand of reluctance towards moves to professionalise' in the social professions, as this involves the creation of distance between workers/clients. This distance can be related to imbalances of power as what is described as 'professional culture' is a way to distinguishes 'us' from 'them'; - i.e. the professional from others. As the core tenets of health promotion are empowerment and participation it is understandable that the traditional model of a profession, with its restricted membership and assumption of particular knowledge and therefore power, is not deemed to be acceptable for health promotion by many, for example, an article discussing learning and health promotion poses the question: Is health promotion exclusively a professional activity? and immediately responds 'certainly not'. If health promotion is truly about empowering and involving individuals, a variety of formal and informal experts can and should contribute to health promotion' (OHP 2004).

The arguments for professionalisation include the need for health promotion to have recognised status and influence if it is to command a high degree of autonomy and respect from other professions (McGhee, 1995). McGhee argues that the ability to control their own area of work forms the greatest distinguishing feature between a profession and other occupations and argued that health promotion in the UK moved towards this when, in 1982, a professional society, The Society for Health Education and Health Promotion Specialists (SHEPS), was formed. It is interesting to note that, in fact, this society was divided by ongoing disagreement about professionalisation and that it has, at least on a UK wide basis, failed to survive the subsumation of health promotion into multidisciplinary public health.

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<sup>65</sup> <http://www.rsph.org.uk/en/health-promotion/collaboration-action-plan/>

<sup>66</sup> Available on page <http://www.rsph.org.uk/en/health-promotion/collaboration-action-plan/>

<sup>67</sup> <http://www.vhpo.net/viewtopic.php?f=4&t=24>

This dilemma posed by professionalisation has continued within the health promotion community up to the present day. On the one hand there are those who continue to espouse full professional status and believe that health promotion will not have creditability and status and will always be perceived as the poor relation of public health if it does not claim professional status. This argument is also linked to practical issues such as levels of pay and career pathways. It is interesting to note that some practitioners support the development of competencies because of issues that could be agreements for professionalisation in fact are strong opponents of any move towards accreditation and attempting to establish professional boundaries and control. Their reasons for supporting competencies include:

- Lower-than-desired credibility for health promotion and health promoters coupled with inconsistent and sometimes
- Minimal understanding on the part of credentialised health professionals (including management of organisations hiring health promoters) about the skill and knowledge sets required to practice health promotion
- Compensation that is not comparable with other public health professionals (community health nurses, public health nutritionists)
- Hiring competitions that do not provide advantage to those with formal training in health promotion. Based on Hyndman (2007).

It has also been considered that, in the light of the development of competencies within public health disciplines, health promoter's risk further marginalisation if they fail to take ownership on a set of competencies that best reflects their unique contribution. All of these points could be used to argue for professionalisation. However, the strong conclusion drawn by practitioners in Canada is that the proposed competencies which they support as an attempt to address these issues should not be seen as an initial step towards the mandatory accreditation of health promoters. It was considered that the process for health promotion to become a formally accredited and regulated profession would be overly rigorous, time-consuming, and potentially divisive. It was further argued that the promotion of health occurs best when the field is participatory, multidisciplinary and significantly informed by promising and best practices. Formalised self-regulation, with or without a legislative framework, does not, it was argued, apply well to most health promotion practitioners in most settings as these approaches are primarily intended to protect the public and control competition within professional fields of practice mostly those if performed by a non-regulated individual, could engender harm to a patient (OPC 2006).

While the development of competencies is not, in itself, an endorsement of moves towards professionalisation, it is necessary to be aware of the perceived link between the two and the intense and at times passionate debate that will be provoked. Within the context of the CompHP Project, the competencies which will be developed will form the basis for professional standards and an accreditation framework. It is envisioned that different countries will engage with the competencies, standards and accreditation framework in differing ways. Whether a country will progress to accreditation will depend on political support for such action, the ease with which such systems can be implemented and the strength and opinions of any national health

promotion professional body. It will, therefore, be up to local health promotion professionals to decide whether they wish to advocate to become accredited and whether they wish to 'professionalise'.

In relation to accreditation the CompHP partners have agreed the following;

*"We understand accreditation for health promotion as a way of ensuring quality practice, as a world-class quality seal, and a benchmark that will enhance various professional profiles and show international recognition to a certain way of working (following health promotion premises and values, etc). We see this as absolutely compatible with having different professional identities other than health promotion, but also enables those whose professional identity is Health Promotion to hold a recognised accreditation and for everyone, it could back them to improve their employability."* (CompHP Controversy Conflict Strategy CompHP Management Plan, Deliverable I, 2009, Pages 22-27)

In relation to the question of health promotion thriving on diversity and that, therefore, attempts to standardise will limit it as a discipline/profession the agreed partner position is:

*"The project aims to develop a quality assurance framework based on competencies and standards. This does not aim to, nor should it, limit the range of people from different backgrounds entering health promotion or diversity and creativity in all aspects of health promotion. The competencies and standards will allow for a framework which forms the basis for accountable practice but will not be overly detailed or prescriptive and practitioners can choose the methods and means by which they implement health promotion"* (CompHP Controversy Conflict Strategy (2009).

While the debate on whether health promotion is, or should be a profession will no doubt continue, the importance of practitioners acting 'professionally' is at the core of the CompHP Project. This means that health promotion practitioners act accountably, develop and share models of best practice and uphold the principles of the Ottawa Charter. The development of core competencies and professional standards will be a major contribution to the capacity for effective and ethical health promotion practice in Europe.

## **CONCLUSION**

This review clearly shows that there is an emerging international literature on the competencies required for health promotion practice. Many countries have made significant progress in identifying and agreeing core competencies and developing competency-based standards and quality assurance systems. The literature also indicates that these developments have an important role to play in informing health promotion training, professional development and accountable practice. However, the global development of such core competencies has been uneven, as many countries lack the resources and support needed for building capacity and the development of health promotion training and practice. Recent efforts such as the

Galway Consensus Statement do, however, represent an important move towards articulating a common set of core values and principles and a shared vision of the domains of core competency for health promotion practice.

The review of developments within the European region also indicates different rates of progress across countries, from well established systems to countries where there is little or no development in this area. Health promotion is an evolving field of practice in Europe and the diversity of socio-economic, cultural and political contexts within the region is reflected in the variable rate of health promotion capacity development across member states. Generally across Europe there is limited experience in this area, however, lessons can be learned from those countries with established systems, both within and beyond the European region. In view of the different stages of development of health promotion across Europe, a coherent framework that will build on national and international developments is needed to guide the development of a comprehensive, yet flexible, system for workforce development and quality assurance.

The review highlights the commonalities that exist across the various frameworks indicating that many share a core set of competency areas derived from a common base of core concepts, values and theories underpinning health promotion practice. However, it is also acknowledged that the area of health promotion competencies, and the related area of competency-based accreditation, is complex and often highly contested. The positioning of health promotion competencies within other domains of practice continues to be debated in many countries where the relationship with multidisciplinary public health and with health education continue to remain unclear. In many countries the terminology used to describe health promotion functions varies considerably depending on workforce development, local structures and national policy focus. However, a consistent reference point for most of the established frameworks continues to be the Ottawa Charter for Health Promotion (WHO, 1986) and the core concepts, values and principles that are outlined in the Charter provide a common conceptual base for characterising global health promotion practice. The socioecological approach to promoting health outlined in the Charter, together with the five indicated action areas, are viewed as providing a distinctive conceptual framework for practice. All the frameworks reviewed in this document embrace the definition of health promotion as articulated in the Ottawa Charter and consistently point to the need for core competencies to reflect the unique and distinctive features of health promotion practice. There is general agreement in the literature that health promotion core competencies need to be based on the specific knowledge and skills required for effective practice, thereby drawing on the ethical, theoretical and research knowledge base of health promotion.

Where there is less consensus in evidence, however, is in relation to who these competencies are designed for, i.e. whether for a specialist health promotion workforce or for a broader workforce of practitioners and professionals where health promotion constitutes part, but not all, of their core function. There is much variation across countries regarding who constitutes the core health promotion workforce. Within Europe, many countries do not have dedicated health promotion posts and therefore, the parameters of health promotion as a specialised field of practice are not



well defined. The majority of frameworks reviewed indicate that the competencies are primarily designed for health promotion practitioners where health promotion is seen as their core function, however, some are also keen to point out that this focus is not meant to exclude others who may also have a remit for health promotion as part of a broader job description.

Promoting the health of populations through the combined actions of the Ottawa Charter requires a particular combination of knowledge and skills to ensure quality health promotion practice. It is becoming increasingly clear that both generic and specialist skills are needed in the development and implementation of evidence-based policy and practice. The strategic leadership and specialist skills required for the effective translation of policy and research into effective and sustainable health promotion practice requires at least two different levels of the workforce: dedicated health promotion specialists who facilitate and support the development of policy and practice across a range of settings; and the wider health promotion workforce drawn from across different sectors such as health, education, employment, community and non-governmental organisations. Continuing professional development and training in health promotion is required at both levels to enhance the quality of practice and to update the skill set required to work within complex and changing social and political contexts. A flexible framework of competencies is, therefore, needed which can be adapted across the workforce depending on the level and range of functions performed.

While many of the existing frameworks are designed for use across all areas of health promotion, most are initially focused at beginner practitioner level or entry level, which is variously defined as at graduate level (Bachelor or Master's degree) of competency and/or at a level of competency that may be expected after a defined number of years in practice e.g. less than five years of experience. Most frameworks are designed so that they may be expanded to incorporate competencies that would be expected at a more senior or advanced level (e.g. five or more years) and competencies required in more specialised areas of practice e.g. for health promoters working in particular topic areas (e.g. community health development, evaluation, social marketing) or working with particular groups (e.g. women, older people, marginalised groups etc.). In some cases different levels of practice are clearly outlined. For example, in the US, the CUP model clearly identifies three levels of health education professional practice, based on the level of degree qualification held and years of experience. In the UK Public Health Skills and Career Framework, nine levels of competence are specified. Most of the health promotion frameworks, however, do not specify different levels but rather seek to outline a basic framework which can then be expanded and applied to different levels of practice and expertise as needed. This approach would appear to offer an acceptable way forward in that the framework can then be adapted to identify different levels of expertise for each competency statement and/or different degrees of emphasis of specific competencies to meet the specific demands of a defined workforce. However, all areas identified as being core competencies should be addressed to some degree if the framework is to be used as a solid base for consistent quality practice.

The majority of frameworks include provision for reviewing the core competencies on an ongoing basis to reflect the changing practice and policy context, priorities for action and the growing knowledge and evidence base in health promotion. Regular reviews of the core competencies is built into most frameworks so that the health promotion workforce is well placed to address new and emerging challenges and to respond appropriately to new contexts.

The relationship of competencies, in terms of skills and knowledge, to other qualities such as values, ethics and cultural competency, are explored in many of the frameworks. All frameworks endorse the core principles of health promotion as underlying the core competencies. For example, the Australian Health Promotion Association outline an ethical framework for the core competencies, which is being used as the foundation for developing a Code of Ethics. The Health Promotion Forum in New Zealand makes a clear commitment to integrate Maori customs and culture into the competency framework and endorses the Treaty of Waitangi alongside the Ottawa Charter, as the basis for health promotion action in Aotearoa/New Zealand. Cultural competencies embracing diversity and inclusiveness, are included in a number of frameworks. It is clear that the ethical and cultural dimensions of practice are of particular importance and value in developing competencies for the practice of health promotion in a multicultural context and therefore, need to be incorporated.

In some countries the debate concerning health promotion competencies is linked with the wider debate about the professionalisation of health promotion. For example, Hyndman (2009) clearly points out that the development of competencies in Canada is for the purposes of agreeing the core skill set required for health promotion practice, and should not be viewed as a step towards health promotion becoming a formally accredited and regulated profession. In other countries, e.g. in the UK and the US, the development of competencies and competency-based standards has been part of a broader development of occupational standards, an overall regulation and professional accreditation process. Views are very divided in the health promotion community concerning the extent to which core competencies, once defined, should then be assessed and linked to a quality assurance or formal accreditation mechanism. While many countries and professional organisations view the credentialling of health promotion as being vital in building workforce capacity and increasing the professional identity of health promotion, others express their concern that any movement in this direction would very much limit the broad multidisciplinary base of health promotion and thereby effectively exclude many of the wider workforce. These diverging views have not been reconciled and it would appear, as pointed out by McQueen (2009), that agreement on core competencies is more likely to be achieved than agreement on the basis on which these competencies can be assessed and accredited.

Concerning the means of how to achieve agreement or consensus, it is clear from the review that the different methodological approaches used in the competency development consultation process give rise de facto to different definitions of what constitutes consensus. A range of development strategies, each with varying strengths and weaknesses, have been used including consultations with representative groups of experts, surveys with a broad base of practitioners, and reviews by independent panels

of experts. These consultations have employed a range of methods including interviews, focus groups, workshops, and consensus building through the Delphi technique. However, how 'experts' are defined and selected, the basis on which consensus is deemed to have been reached (i.e. what level of agreement or disagreement, defined either quantitatively or qualitatively, is taken as indicating consensus), is often not made explicit in the studies reviewed. Indeed the very adoption of a consensus approach has been accused of leading to a more bland, middle-of-the-road depiction of health promotion, resulting in the more radical and innovative elements of health promotion practice being squeezed out in the process of reaching common agreement. That said, consensus building has been a core feature of EU policy development. Likewise, the active engagement and participation of the health promotion community in a broad based consultation process on competency development is very much in keeping with the ethos and principles of health promotion practice. Drawing on lessons from the international studies, it would appear that a multi-method, layered approach to development, incorporating as broad a base of feedback as possible is needed in building consensus within the European context. The research methods used for consultation need to be transparent with a full and clear description of how samples are selected, and how criteria have been set for data analysis in determining the basis on which consensus will be deemed to have been reached.

Another criticism that the review highlights is that many of the competency development approaches are based on current practice and, therefore, do not embrace a forward-looking approach where current and future trends, challenges and opportunities for advancing health promotion, are considered in informing the development process. A strategic approach for future planning is required that will consider the competencies that are needed for health promotion practice not only in the current context but over the next 10-20 years. Health policy priorities and work practices are in a constant state of change. New and emerging health promotion theory and research will need to be incorporated into the competency development process. Therefore, the capacity to respond to changing social, scientific, political and policy environments without compromising core values and principles of practice will be an important feature of a competent health promotion workforce skilled for the future. A competency development approach should, therefore, seek to embrace a forward-looking perspective in determining the required competencies and skills to address complex health issues within rapidly changing social and political contexts. This will be particularly important in the context of a changing and expanding European Union.

In conclusion, despite the challenges and the debates that are evident from the literature review, the competency approach has generally been welcomed in relation to health promotion workforce capacity building. Few would argue against the view that a competent workforce, with the necessary knowledge and skills to translate policies and research into effective action, is critical to the future development and sustainability of health promotion. Supporting capacity building and training of the health promotion workforce is a central plank of the infrastructure required for promoting population health in Europe. Having qualified human resources in health

promotion is essential to deliver quality health promotion actions, and this includes workforce education and training ranging from generic to specialist skills in the development and implementation of evidence-based policy and practice. A competent and skilled workforce is urgently needed in order to address the determinants of health and to close the gap on the growing health inequities within and between countries. The European health promotion workforce needs to be able to contextualise health policies and to translate EU and national health strategies into effective health promotion actions tailored to diverse social, cultural, economic and political contexts and the realities of population groups, settings and communities in the European region. Ensuring that health promotion practice is informed by an agreed and defined body of knowledge, values and skills, is critical to building a competent and well prepared workforce in Europe. Developing general agreement on the core competencies for the health promotion workforce is, therefore, key to building sustainable, effective practice for the future.

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