Global Progress in Core Competencies and Quality Assurance for Health Education and Health Promotion: Articles

The CompHP Core Competencies Framework for Health Promotion in Europe

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Abstract

Background. The CompHP Project on Developing Competencies and Professional Standards for Health Promotion in Europe was developed in response to the need for new and changing health promotion competencies to address health challenges. This article presents the process of developing the CompHP Core Competencies Framework for Health Promotion across the European Union Member States and Candidate Countries. Method. A phased, multiple-method approach was employed to facilitate a consensus-building process on the development of the core competencies. Key stakeholders in European health promotion were engaged in a layered consultation process using the Delphi technique, online consultations, workshops, and focus groups. Findings. Based on an extensive literature review, a mapping process was used to identify the core domains, which informed the first draft of the Framework. A consultation process involving two rounds of a Delphi survey with national experts in health promotion from 30 countries was carried out. In addition, feedback was received from 25 health promotion leaders who participated in two focus groups at a pan-European level and 116 health promotion practitioners who engaged in four country-specific consultations. A further 54 respondents replied to online consultations, and there were a number of followers on various social media platforms. Based on four rounds of redrafting, the final Framework document was produced, consisting of 11 core domains and 68 core competency statements. Conclusions. The CompHP Core Competencies Framework for Health Promotion provides a resource for workforce development in Europe, by articulating the necessary knowledge, skills, and abilities that are required for effective practice. The core domains are based on the multidisciplinary concepts, theories, and research that make health promotion distinctive. It is the combined application of all the domains, the knowledge base, and the ethical values that constitute the CompHP Core Competencies Framework for Health Promotion.

Keywords
core competency framework, Europe, health promotion competencies, workforce capacity development

There is increased emphasis on strengthening health systems to deliver on improved population health in global, European, and national health policies (Institute of Medicine, 2010; International Union for Health Promotion and Education [IUHPE], 2011; World Health Organization [WHO], 2008, 2010). This calls for investment in the implementation of health promotion policies and the development of workforce capacity in order to ensure that the health promotion workforce are equipped with the required competencies to implement current knowledge, research, and best practice. Identifying and agreeing on the core competencies for effective health promotion practice, education, and training is acknowledged as an essential component of developing and strengthening workforce capacity to improve population health (Barry, 2008; Battel-Kirk & Barry, 2008; WHO, 2009).

In the European context, health promotion is an evolving field of practice with a diverse and growing workforce drawn from a broad range of disciplines. Given this diversity, there is a need for agreed core competencies that delineate the specific body of skills, knowledge, and expertise that is distinctive to health promotion in order to unify and strengthen health promotion workforce capacity (Allegrante et al., 2009; Barry, Allegrante, Lamarre, Auld, & Taub, 2009).

The CompHP Project on Developing Competencies and Professional Standards for Health Promotion in Europe was developed to respond to the demand for new and changing health promotion competencies required to address current...
health challenges including health inequities and noncommunicable diseases and to promote healthy ageing, positive mental health, and well-being. The development of a European competency-based system was seen as providing the basis for building a competent and effective health promotion workforce capable of translating into action the key priorities identified in European and global health strategies and policies. The Project also sought to provide the basis for effective and ethical practice and quality-assured education and training to agreed standards.

The CompHP Project, which was funded by the Executive Agency for Health and Consumers for the period 2009-2012, brought together 24 European partners from across the policy, practice, and academic sectors, together with leading international experts on competency-based approaches to health promotion. Through a wide-ranging consultation and consensus building process, CompHP engaged with key stakeholders in health promotion in Europe and built on existing European and global competency frameworks for health promotion. In particular, the CompHP Framework was informed by the domains of core competency identified in the Galway Consensus Conference Statement (Allegrante et al., 2009) and other existing frameworks (Battel-Kirk, Barry, Taub, & Lysoby, 2009) and drew on health promotion capacity research conducted in Europe (Battel-Kirk & Barry, 2008; Santa-Maria Morales & Barry, 2007).

This article presents the process of developing the CompHP Core Competencies Framework for Health Promotion, which was published as a Handbook in 2011 (Dempsey, Battel-Kirk, & Barry, 2011). The core competencies formed the cornerstone of the Project as they provided the foundation for the development of the CompHP Professional Standards (Speller, Parish, Davison, & Zilnyk, 2012) and the Pan-European Accreditation Framework (Van der Zanden, Schipperen, & Battel-Kirk, 2012).

**Developing Core Competencies: Definitions and Context**

A glossary of the agreed definitions of key terms used in the Project was developed to ensure shared understanding between partners and with stakeholders. The following definitions were employed throughout the project development:

**Competencies:** These are a combination of the essential knowledge, abilities, skills, and values necessary for the practice of health promotion (adapted from Shilton, Howatt, James, & Lower, 2001).

**Core competencies:** These comprise 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 in order to work efficiently, effectively, and appropriately in the field (Australian Health Promotion Association [AHPA], 2009).

A health promotion practitioner, for the purpose of the CompHP Project, is defined as a person who holds a graduate or postgraduate qualification in health promotion or a related discipline and whose main role and function is health promotion as described by the Ottawa Charter for Health Promotion (WHO, 1986) and subsequent WHO declarations (WHO, 1988, 1991, 1997, 2000, 2005, 2009). Health promotion is, therefore, understood to be “the process of enabling people to increase control over, and to improve, their health” (WHO, 1986) and is viewed as a comprehensive social and political process that embraces not only actions directed at strengthening the skills and capabilities of individuals but also actions directed toward changing social, environmental, and economic conditions that influence health (Nutbeam, 1986).

The term **health promotion action** is used in the CompHP Framework to describe programs, policies, and other organized health promotion interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable, and multistrategy in nature (WHO, 1997) and aim to improve health and reduce health inequities.

Although job titles and academic course titles in different European countries may not always include the term **health promotion**, the Core Competency Framework is designed to be relevant to all practitioners whose main role reflects the definition and principles of health promotion as defined in the Ottawa Charter (WHO, 1986). It is envisaged that the CompHP Core Competencies Framework will also be useful to those working in other professional areas whose role includes health promotion and those in other sectors who are involved in partnerships to promote health.

The health promotion workforce is at different stages of development in Europe with varying levels of professional identity, education, and career development within and across countries (Battel-Kirk & Barry, 2008; Santa-Maria Morales & Barry, 2007). Following discussion among the project partners, it was agreed that the CompHP Core Competencies would be at “entry level,” that is, the level at which a practitioner enters practice. However, the CompHP Core Competencies could be used for developing more advanced competencies for practitioners working at senior management level in health promotion or to inform the development of more specialized competencies for those working in specific settings. It was also recognized that those using the CompHP Core Competencies may wish to identify different levels of expertise for some, or all, or to emphasize some competencies to a greater degree than others. However, as these are core competencies, all must be addressed if they are to be used as the basis for consistent, quality health promotion practice that can be recognized internationally and be accredited through a pan-European accreditation system.
Table 1. Overview of the CompHP Core Competencies Framework Development Process

<table>
<thead>
<tr>
<th>Phase</th>
<th>Activity</th>
<th>Framework Draft</th>
<th>Time Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Literature review</td>
<td>1</td>
<td>September 2009 to May 2010</td>
</tr>
<tr>
<td></td>
<td>Mapping across existing Frameworks</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>First draft of Framework</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Sample frame for Delphi survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Delphi survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Pilot</td>
<td>1</td>
<td>February 2010</td>
</tr>
<tr>
<td></td>
<td>Round 1</td>
<td>2</td>
<td>March 2010</td>
</tr>
<tr>
<td></td>
<td>Round 2</td>
<td>3</td>
<td>April 2010</td>
</tr>
<tr>
<td></td>
<td>Focus groups with health promotion experts</td>
<td>3</td>
<td>July 2010 to September 2010</td>
</tr>
<tr>
<td>3</td>
<td>Online consultations</td>
<td>4</td>
<td>October 2010 to January 2011</td>
</tr>
<tr>
<td></td>
<td>Workshops and focus groups (4 European countries)</td>
<td></td>
<td>January 2011 to March 2011</td>
</tr>
<tr>
<td></td>
<td>Preparation of handbook for publication</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Method

Development Process

A phased, multiple-method approach (Table 1) was employed to facilitate the consensus-building process on the core competencies that sought to engage the key stakeholders in European health promotion in a wide-ranging consultation process. Following a detailed literature review and mapping process, the Delphi technique, together with online consultations, workshops, and focus group methods, were employed at pan-European and country level to capture the diversity of views of the health promotion community in Europe. In addition to the input from key stakeholders across Europe, the CompHP Project Partners and International Expert Advisory Group contributed to each stage of the development process. The stages of this development process will now be described.

Literature review. The literature review sought to identify existing competency frameworks that could inform the CompHP development process, including the methodologies used in their development. The review focused on the international literature on competencies and their development in health promotion and related fields, in both the published and gray literature between 1990 and 2009. Initially, only literature available in English was included, but this was later expanded to include sources in other languages where translation was available, comprising mainly documents provided by Project Partners. To encompass differences in the terminology and job titles used across Europe, reference was also made to the literature on public health and health education competencies.

Mapping and comparing frameworks. A mapping process (adapted from LaFond & Brown, 2003) was used to analyze and compare the main elements of existing health promotion competency frameworks. The most commonly occurring competency domains from these frameworks (AHPA, 2009; Health Promotion Forum of New Zealand, 2000; Hyndman, 2009; Public Health Resource Unit & Skills for Health, 2008) were identified and mapped, drawing on core domains from the Galway Conference Consensus Statement (Allegrante et al., 2009) and feedback received from a global consultation following its publication.

Delphi surveys. The Delphi method was the key research method used in building consensus on the core competencies. Delphi is a multistage process in which questions are posed, the results analyzed, and findings reported back to participants. The decision to use the Delphi method was based on the fact that it is commonly used in consensus-building processes (Howat et al., 2000; Shilton et al., 2008; Witt & de Almeida, 2008) and facilitates inclusion and participation of a large number of respondents across wide geographical areas (Howze & Dalrymple, 2004; Jairath & Weinstein, 1994; Thompson, 2009).

There is no agreement in the literature on the optimal number of rounds to be used in the Delphi process, with variables such as the time available and how the consensus process begins (i.e., with a broad question that requires refinement or with a list of specific questions) influencing the decision (Keeney, Hasson, & McKenna, 2006). As time was limited and the Delphi survey posed specific questions based on draft documents, two rounds were considered sufficient for this development process.

Consensus-building approach. A consensus-building approach was employed, which was deemed essential in view of the diversity of health promotion development across the European Union (EU) region. Most consensus processes seek unanimity but settle for overwhelming agreement that goes as far as possible toward meeting the interests of all stakeholders (Susskind, 1999). It is recommended in the literature that there should be agreement on what will constitute “consensus” before the process begins (Keeney et al., 2006; Susskind, 1999; Williams & Webb, 1994). There are also differing opinions...
on when consensus is achieved, including, for example, when there is a convergence of opinion, when a point of diminishing returns is reached (Fink, Kosecoff, Chassin, & Brook, 1984), or when an agreed “consensus point” has been reached (Hasson, Keeney, & McKenna, 2000; Keeney et al., 2006). It was agreed that for the purposes of the CompHP Project, a consensus point for retaining a domain or competency statement would be reached when 70% of respondents in the Delphi surveys scored 3.5 or more on a 5-point Likert-type scale for each of the rated questions. This score is at the higher end of the levels for consensus discussed in the literature (B. Green, Jones, Hughes, & Willmas, 1999; P. J. Green, 1982; Hasson et al., 2000; Hsu, 2007; Loughlin & Moore, 1979: National Commission for Health Education Credentialing (NCHEC), Society for Public Health Education (SOPHE), & American Association for Health Education (AAHE), 2006; Witt & de Almeida, 2008).

Qualitative feedback was also an important element of the consensus process, and it was agreed that participants’ responses to open questions in the Delphi survey would be analyzed and grouped into common themes. This feedback further informed the decisions made on retaining, removing, or modifying each domain and competency statement and in revising other elements (e.g., the Glossary) in successive drafts of the Framework.

**Participants**

The sample frame for the consultations comprised a list of project stakeholders, developed by the IUHPE in their role as project partners, based on an exhaustive search of health promotion experts and networks across Europe. The list included contact details for stakeholders together with information on their area of expertise within health promotion (i.e., policy, practice, or academia), the level of their role (local, regional, or national level) and their experience in, or knowledge of, competency approaches.

The target for the Delphi sampling was to identify two respondents with expertise in health promotion at national level from each of the areas of policy, practice, and academia in 34 countries (comprising 27 EU Member States, three Candidate Countries, three European Economic Area countries, and Switzerland), resulting in a total of 204 potential respondents.

To identify the sample, the stakeholder list was first analyzed to ascertain if there were sufficient numbers of experts in each country. Where this was the case, respondents for the survey were selected by first giving preference to those with experience in the competency approach, followed by random selection of respondents from the academic, practice, and policy sectors in the order in which they appeared on the list. Where there were not a sufficient number of experts, a key stakeholder in that country was asked to nominate suitable health promotion experts. Respondents were identified in all of the 34 target countries, however, in six countries the full quota could not be identified, resulting in a sample of 180 respondents.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**Data Collection Tools**

**Development of the Delphi questionnaire.** The Delphi questionnaire comprised 123 questions in Round 1 and 100 questions in Round 2. The questionnaires were designed to assess respondents’ levels of agreement with each domain and competency statement using a 5-point Likert-type scale (Table 2). Respondents were also asked if, in their opinion, any of the domains or competencies should be removed or others added. Questions on the potential uses of the Framework and its relevance to health promotion practice were also included.

An online survey, using Survey Monkey, was the most appropriate data collection tool for the Delphi, given the wide geographical spread of the intended respondents (Dilman, 2007; Pan, 2010; Wright, 2005). Invitations to participate in both rounds of the Delphi survey were sent to respondents in an e-mail that explained the purpose of the consultation and contained a link to the questionnaire. Respondents were also sent the relevant draft of the Framework document and the questionnaire as e-mail attachments to allow them to read and consider both before completing the questionnaire. In Round 2 of the survey, a table showing the findings from Round 1 and the resulting changes to the draft Framework was also sent to respondents.

**Focus groups and workshops.** A series of focus groups and workshops were conducted to explore in more depth the opinions of health promotion experts and health promotion practitioners on the drafts of the Framework.

To maximize continuity in data collection across all groups, structured questions for the focus groups and workshop facilitators were agreed, focusing on three key areas:

a. WHAT are your views of the draft Framework?

b. HOW do you see the Framework being used in your country?

c. WHO do you think will use the Framework?

The first round of focus groups comprised respondents to an invitation, sent as part of the Round 1 Delphi survey, to those who planned to attend the 20th IUHPE World Conference on Health Promotion in July 2010. In the second round, a convenience sample of national health promotion stakeholders was invited to participate in focus groups and workshops facilitated by the CompHP Partners in Estonia, Ireland, Finland, and the Czech Republic.
Online discussion forum and social media. In Phase 3 of the development process, an online discussion forum, together with a short online questionnaire, was used to reach the wider health promotion community in Europe. A CompHP Facebook page and a Twitter account were also set up, both of which included invitations to join the discussion forum and complete the questionnaire, together with links to both. Those visiting the discussion forum were asked to view Draft 4 of the Framework (which was available on the Project website) before completing the questionnaire and contributing to the discussion. Prompt questions, similar to those used in focus groups, were posted on the forum to stimulate discussion.

Participants were invited to contribute to the online consultation through the following:

- E-mails with links to the discussion forum and short questionnaire to all in the Delphi sample, with a request that these be forwarded to relevant colleagues in their country
- Invitations to other health promotion organizations, policy makers, academic departments, and all members of the IUHPE European Region
- Invitations on the CompHP Facebook, Twitter, and the Project websites

Data Analysis

The Delphi data were analyzed quantitatively, measuring the mean for each domain and competency statement, with consensus agreed as occurring when 70% of respondents scored 3.5 or more on a 5-point Likert-type scale for each of the rated questions.

The responses to open questions in the Delphi surveys were collated and analyzed thematically. The discussion and feedback from the focus groups and group discussions were transcribed and analyzed to identify common themes and issues arising.

The mean scores from rated questions, together with the main themes arising from the qualitative data, formed the basis for the decisions made to retain, remove, or modify each domain and competency statement and in revising other elements (e.g., the Glossary) in successive drafts of the Framework.

Results

Phase 1: Literature Review and Mapping Process

The literature review (Dempsey, Barry, & Battel-Kirk, 2010) identified a number of existing competency frameworks for health promotion, public health, and health education globally (AHPA, 2009; Health Promotion Forum of New Zealand, 2000; Hyndman, 2009; NCHEC, SOPHE, & AAHE, 2006; Public Health Resource Unit & Skills for Health, 2008) and in a smaller number of European countries (Health Scotland, 2005; Santa-Maria Morales & Barry, 2007; Santa-Maria Morales et al., 2009).

Commonalities in both the content of the frameworks and the methods used in their development were identified, but no one format or method had been replicated exactly. The level of the competencies in the existing frameworks also differed, with some (AHPA, 2009) referring to “entry level” and others (e.g., Health Promotion Forum of New Zealand, 2000) using a more complex three-level matrix.

However, despite these differences, there was agreement in the literature that core competencies should identify what is specific and unique to health promotion and that the development process must be rigorous, systematic, and inclusive and firmly grounded in the core principles and practice of health promotion (Dempsey et al., 2010). 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), together with the papers that informed its development (Allegrante et al., 2009; Barry et al., 2009; Battel-Kirk et al., 2009; Santa-Maria Morales et al., 2009), proved to be a vital resource for the development process.

A mapping process was used to identify the core domains employed across the existing frameworks in order to inform decisions on which domains to include in Draft 1 of the Framework. The most commonly occurring domains from the existing competency frameworks were mapped against the core domains identified in the Galway Conference Consensus Statement (Allegrante et al., 2009), together with the domains of Communication, Knowledge, and Ethics, which were also included in a number of competency frameworks (see Table 3). The term Catalyzing Change was subsequently changed to Enabling Change in order to reflect a broader understanding of an empowerment and enabling approach to health promotion. Based on the mapping process, 10 core domains and associated competencies were identified for inclusion in the first draft of the Framework.

The first draft of the Framework. Draft 1 of the Framework comprised 10 core competency domains and 79 core competency statements. The core domains included the following: Enabling Change, Leadership, Needs Assessment, Planning, Implementation, Evaluation and Research, Advocacy, Partnership, Communication, and Knowledge. An introductory section, which outlined the background to the CompHP Project, the development process to date, definitions of key terms, the ethical values of health promotion underpinning the Framework, and a glossary of terms, was also included. It was also indicated that the Framework was designed for use by “entry-level practitioners” as agreed by the CompHP Project Partners (Dempsey et al., 2011).

Phase 2: Delphi Surveys

piloted the online questionnaire with a response rate of 68% \( (n = 13) \). All competencies and domains exceeded the agreed consensus point mean of 3.5 in the pilot phase. However, qualitative feedback led to the rewording of some competency statements in order to improve clarity and consistency and to a revision of the Glossary resulting in Draft 2. The online questionnaire was modified to reflect these changes and to make it more user-friendly.

In Round 1 of the Delphi, responses were slow to return, despite reminders and the deadline for replies being extended twice. The final response rate was 45%, comprising 81 responses from 30 of the 34 countries targeted. These responses were added to those from the pilot (combined response \( n = 94 \)) and the means and percentages were calculated for each rated question. The mean ratings for the domains ranged from 4.43 to 4.62 (Table 4) and the competency statements scored mean ratings ranging from 4.19 to 4.60, indicating that all exceeded the retention point of 70% of responses scoring 3.5 or higher (i.e., consensus).

Responses to the overall framework were generally positive, for example, “the framework is comprehensive and clear, summarizing the present international shared state of art of health promotion” and that “it is an important contribution to public health.”

Common concerns emerging from the qualitative data included the need to remove repetition, revise the order of the domains, and simplify the wording. Although most responses indicated that the Framework reflected health promotion as currently practiced, there were a few exceptions, for example, that it was “too theoretical,” “too ambitious,” and “too high for entry-level practitioners.”

A number of respondents queried the appropriateness of the Advocacy competencies, which were perceived as being “too political,” and others considered the Leadership competencies were too advanced for entry-level practitioners.

Based on this feedback, the following changes were made:

- Reducing the number of competencies from 79 to 60
- Changing the sequence of the domains
- Renaming the “Partnership” domain as “Mediate Through Partnership” to better reflect the Ottawa Charter (WHO, 1986) action area
- Reworking some competencies to reflect a more attainable level (e.g., “to contribute to” rather than “undertake” or “lead on”)

There was debate on whether the Knowledge Base should be a stand-alone domain or incorporated into all other domains, and this led to the development of a diagram to illustrate the relationship between the domains. The findings from Round 1 of the Delphi survey and the resulting revised draft (Draft 3) were discussed at a CompHP Project meeting in May 2010 and circulated to the International Expert Advisory Group for comment.

**Round 2 Delphi survey.** The Round 2 questionnaires comprised 100 questions that focused mainly on respondents’ opinions on Draft 3 of the Framework. Seven respondents from Round 1 indicated that they could not participate in Round 2 and were replaced by 7 nominated experts, maintaining a sample of 180. Responses to Round 2 \( (n = 61; 33.33\%) \) reflected a level of attrition common in Delphi surveys (Keeney et al., 2006; Keeney, Hasson, & McKenna, 2001; Williams & Webb, 1994). In Round 2, the mean scores on all domains and competencies again exceeded the retention point of 3.5 (i.e., the predetermined consensus point) as shown in Table 4.

Qualitative feedback was again mainly positive, for example, that the Framework “should improve current health promotion practice” and that “overall the competencies are great and a huge improvement on the first round.”

Some concerns reemerged, however, including continued repetition, inconsistencies in terminology, and the overall length of the document. Some competencies were again
considered as being at too advanced a level, for example: “While I strongly agree with this competency, I have reservations about the expectation for an entry-level practitioner” and that the Framework was “more how it should be rather that it really is in practice.” A small number of respondents again indicated that the Knowledge Domain should be incorporated into each of the other domains. Some reservations were also expressed about the terminology used in the Leadership Domain, for example, “they are broadly defined and assume seniority within organizations so I suggest some rewording.”

A new area of concern emerging in Round 2 was that “ethical values” and the “rights-based approach to health” were not sufficiently prominent in the Framework. Comments included the following: “one of the gaps in this document is the lack of reference to ethical practice,” “should include the right to health,” and “don’t want to see the number of domains increased but do want to see a stronger mention of values and ethics.”

Focus groups. A total of 25 participants (19 experts from 17 European countries and 6 members of the International Expert Advisory Group) contributed to the focus groups held at the 20th IUHPE World Conference on Health Promotion in July 2010.

The feedback from this group was generally positive, for example: “I am happy, especially as it goes back to the core of health promotion, the Ottawa Charter”; “it explains in more detail what health promotion is about, what health promotion practitioners do”; and “it will empower and facilitate the work of health promotion.” The Framework was considered to be relevant and potentially useful across all sectors, for example, in developing academic courses, job descriptions, and performance appraisal tools.

The concerns expressed in the focus groups reflected many of those already noted from the Delphi surveys, including that the level was possibly too high, that more prominence needed to be given to ethical values and human rights approaches to health, and that the positioning of the Knowledge domain needed to be reviewed.

Revising Draft 3. The findings from Round 2 of the Delphi survey and the focus groups led to a reconfiguration of the Framework. Some of the competency statements, for example, Leadership, were again reworded to reflect a more attainable level for entry-level practitioners. The overall number of competency statements was reduced from 60 to 45 and “Ethical Values,” which had been included in the Introduction section of the Framework, was included as a core domain. The diagram illustrating the Framework was modified to emphasize that the Ethical Values and the Knowledge Domains underpin the other domains (see Figure 1) and the integral coherence of all elements was stressed: “it is the combined application of the core competencies, integrated with health promotion Knowledge and Ethical Values, which constitute the CompHP Core Competency Framework for Health Promotion.”

A summary of the findings from Phase 2 and the resulting proposed changes to Draft 3 were sent to the CompHP Project Partners and the International Expert Advisory Group and were accepted with minor modifications. The resulting Draft 4 was next offered for online consultation.

### Table 4. Results From the Delphi Surveys: Rounds 1 and 2

<table>
<thead>
<tr>
<th>Core Competency Domain</th>
<th>Number of Competencies Draft 1, Pre Mean</th>
<th>Draft 2, Post Mean (%)</th>
<th>Number of Competencies Draft 2, Pre Round 1 Mean (%)</th>
<th>Number of Competencies Draft 3, Post Round 1 Mean (%)</th>
<th>Number of Competencies Draft 3, Pre Round 2 Mean (%)</th>
<th>Number of Competencies Draft 4, Post Round 2 Mean (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling change</td>
<td>4.30</td>
<td>6 6</td>
<td>4.49 (95.5)</td>
<td>6 5</td>
<td>4.60 (96.7)</td>
<td>5 5</td>
</tr>
<tr>
<td>Leadership</td>
<td>4.80</td>
<td>9 9</td>
<td>4.52 (95.4)</td>
<td>9 5</td>
<td>4.43 (91.7)</td>
<td>5 6</td>
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<tr>
<td>Assessment</td>
<td>4.43</td>
<td>7 7</td>
<td>4.57 (95.4)</td>
<td>7 8</td>
<td>4.42 (98.6)</td>
<td>8 7</td>
</tr>
<tr>
<td>Planning</td>
<td>4.63</td>
<td>9 9</td>
<td>4.52 (94.2)</td>
<td>9 6</td>
<td>4.63 (91.7)</td>
<td>6 5</td>
</tr>
<tr>
<td>Implementation</td>
<td>4.57</td>
<td>7 7</td>
<td>4.46 (95.3)</td>
<td>7 7</td>
<td>4.46 (96.6)</td>
<td>7 5</td>
</tr>
<tr>
<td>Evaluation and research</td>
<td>4.38</td>
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<td>4.45 (91.9)</td>
<td>9 5</td>
<td>4.57 (95)</td>
<td>5 5</td>
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<td>Advocacy</td>
<td>4.50</td>
<td>11 10</td>
<td>4.43 (93)</td>
<td>10 7</td>
<td>4.57 (95)</td>
<td>7 5</td>
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<tr>
<td>Partnership</td>
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<td>4.52 (93.3)</td>
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<td>Communication</td>
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<td>Knowledge</td>
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<td>4.44 (93)</td>
<td>9 7</td>
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<td>Total</td>
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<td>79</td>
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*Knowledge domain competencies moved to overarching domain.*
Phase 3: Consultation With the Health Promotion Workforce in Europe

Phase 3 consisted of a consultation with the wider health promotion workforce across Europe, which comprised the following:

- An online discussion forum hosted on the IUHPE website
- A short questionnaire requesting feedback on the Framework (11 questions)
- Workshops and focus groups at country level, which were facilitated by CompHP Partners in Czech Republic, Estonia, Ireland, and Finland

The discussion forum received a total of 536 views, indicating that it was a useful tool for dissemination and with potential for data collection. Although only five people participated in the forum discussion, they indicated that the competencies were well designed and were an interesting development for the health promotion profession and two stated that they were already using the Framework in academic settings.

Some 54 respondents from 16 of the 34 target countries and two non-EU countries responded to the short questionnaire, with the majority (44.4%) from academic settings, followed by those from practice (31.5%), policy, and other settings (24.1%).

Responses to the questionnaire indicated the following:

- 89.1% considered that the Framework was “good” or “very good.”
- 90% considered that the competencies identified were “core and essential to health promotion practice.”
- 98% judged that although all the core competencies may not be used at one time, health promotion practitioners should be expected to have an understanding or knowledge of all.

![Figure 1. The CompHP Core Competencies Framework for Health Promotion](image-url)
93% agreed that there were health promotion practitioners in their country who matched the definition given in the Framework.

91% agreed that the Framework will be useful in the context of capacity building and forward planning in Europe over the next 20 years.

The social media platforms used proved useful as, by the end of the consultation, 24 “friends” of the Project signed up on Facebook, postings on Facebook received a maximum of 463 impressions (i.e., number of potential views for each post), and the CompHP Twitter site had 10 followers.

Phase 3 country consultations. A total of 116 participants engaged in the four country-specific consultation groups. Feedback from all groups indicated that the scope and content of the Framework was appropriate, although there were again comments on the level of the competencies being “high and challenging.” It was noted that some practitioners might not meet the educational qualifications specified in the Framework but that it could help such practitioners identify gaps in their academic profile and formalize their experience for employment or accreditation purposes. It was also considered that the Knowledge Base needed to be stronger if it was to clearly differentiate health promotion from other areas such as public health.

The health promotion workforce and the established professional organizations were identified as the main drivers for the implementation of the Framework. The lack or limited size of such professional organizations, limited interest from employers, and a lack of understanding of health promotion were identified as potential barriers.

Finalizing the Framework. Based on the feedback from Phase 3, the final changes to the Framework were completed to include 11 core domains and 68 competency statements (see the appendix). Information was also added on how the Framework could be used in different settings and contexts, by those with a partial role in health promotion, and by those who do not meet the specified educational criteria.

Finally, following endorsement by the International Expert Advisory Group and approval from the Project Partners, the CompHP Core Competencies for Health Promotion Framework Handbook (Dempsey et al., 2011) was published on the Project website (http://www.iuhpe.org/?page=614&lang=en), together with short versions in English, French, and Spanish. The Framework was also disseminated to all who participated in the development process and other key stakeholders across Europe.

Discussion

The CompHP Core Competencies Framework for Health Promotion provides a resource for health promotion workforce development in Europe, through articulating the necessary knowledge, skills, and abilities that are required for effective practice. The core domains are based on the multidisciplinary concepts, theories, and research that make health promotion distinctive and build on previous work in this area globally. It is the combined application of all the domains, the knowledge base, and the ethical values that constitute the CompHP Core Competencies Framework for Health Promotion.

The consensus-building process employed multiple research methods with key stakeholders in health promotion policy, practice, and academia in Europe, who were engaged through online consultations and social media, an innovation in competency development. The development process emphasized transparency at each stage and endeavored to foster a sense of participation and ownership within the health promotion community.

Through the widespread consultation, and the input of the CompHP Project Partners and International Expert Advisory Group, the development process sought to build on health promotion expertise and knowledge in different settings and contexts across Europe. This input also ensured that the final Framework was inclusive of the views of practitioners from countries with different levels of development of health promotion, and from different political, cultural, and economic environments. The consensus-building process, therefore, sought to ensure that the final Core Competencies Framework is as relevant, succinct, meaningful, and useable as possible for a pan-European health promotion audience with diverse languages and working across diverse settings.

The Framework was firmly grounded in the core principles and practice of health promotion from its inception. Shared understandings of the core concepts and terminology used were supported across the diverse European health promotion community by providing agreed definitions in a well-referenced Glossary. Ongoing feedback on the format and terminology supported the development of the Framework, which is as clear and as succinct as possible, while capturing the complexities of health promotion practice and its ethical dimensions.

In keeping with many other existing frameworks, the CompHP Framework is designed for use by entry-level, or beginner, practitioners, with a recognized graduate or postgraduate qualification. The issue of the core competencies being at quite a high and challenging level emerged repeatedly in the consultation process. However, given that the competencies are designed for practitioners whose main role and function in health promotion, it was deemed appropriate to keep the core competencies at a level required for professional practice by those graduating from health promotion educational programs, as reflected in comparable frameworks in other countries. It is also recognized that the Framework could be expanded to incorporate competencies that would be expected at a more senior or advanced level and those required in more specialized areas of practice, for example, health promotion practitioners working in areas such as noncommunicable diseases and promoting population mental health and healthy ageing, to name but a few. The Framework can 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 the defined workforce. However, all areas identified as being core competencies should be addressed if the Framework is to be used as a solid basis for quality assurance of health promotion practice, education, and training.

Limitations

Although the development process was successful in producing the CompHP Core Competencies Framework based on consensus, it is important to recognize certain limitations. Every effort was made to incorporate a broad base of feedback from across the EU member states and candidate countries; however, it is clear that the response base was not totally inclusive with limited or no responses received from a small number of countries. In addition, certain stakeholder groups were underrepresented. For example, greater engagement with employer groups/organizations would have been desirable as their views on, and ownership of, the development process would be an important influence on the actual implementation of the Framework once developed.

An argument could be made for employing a more representative sample of practitioners rather than a consensus-building process among selected national experts. However, the latter approach was chosen based on the experiences of other successful competency development initiatives and the fact that a comprehensive database of health promotion practitioners in Europe does not currently exist.

Despite the multimethod approach adopted, the consultation process was restricted in its length and breadth because of the limited project time frame and resources. However, as consensus was reached in both rounds of the Delphi and the feedback was mainly positive, it is questionable if further rounds would have added to the depth or quality of the process or the resulting Framework. With more time and resources, however, it may have been possible to widen the overall levels of participation, both within and across countries, in the development process, especially those countries with a low response rate. Extending the consultation process to also consider competencies across the health promotion career hierarchy, that is, beyond entry level only, would also have been beneficial. However, in view of the time constraints, and based on discussions with partners, it was deemed appropriate to restrict the consensus-building exercise to gaining agreement on entry-level requirement at this stage, with further developments and adaptations being possible once the foundation was agreed.

Conclusions

The development of workforce capacity in health promotion is a central plank of the infrastructure required for promoting population health in Europe. The CompHP Core Competencies Framework for Health Promotion provides an agreed description, within the project time frame available, of the essential knowledge, abilities, skills, and values that are needed to inform effective health promotion practice. The CompHP Framework provides a resource for workforce preparation and development in health promotion in Europe based on a wide-ranging consultation and consensus-building process. Although developed within a European context, the CompHP Core Competencies Framework will also be useful for health promotion competency development globally. From correspondence with the Project to date, it appears that the Framework has relevance for a number of countries worldwide who are engaged in similar competency development processes. The Framework can be used as a stand-alone document, but in the context of the CompHP Project, it forms the basis the CompHP Professional Standards and Pan-European Accreditation Framework. The Framework may also be expanded and applied to different levels of practice and expertise. Although the Framework has been ratified by a wide-ranging consultation, it must be acknowledged that this version will need to be periodically reviewed and revised as experience with the competencies accumulates and the field of health promotion itself evolves.

Appendix

Ethical Values Underpinning Health Promotion Core Competencies

Ethical values and principles for health promotion include a belief in equity and social justice, respect for the autonomy and choice of both individuals and groups, and collaborative and consultative ways of working. Ethical health promotion practice is based on a commitment to

- Health as a human right, which is central to human development
- Respect for the rights, dignity, confidentiality, and worth of individuals and groups
- Respect for all aspects of diversity, including gender, sexual orientation, age, religion, disability, ethnicity, race, and cultural beliefs
- Addressing health inequities, social injustice, and prioritizing the needs of those experiencing poverty and social marginalization
- Addressing the political, economic, social, cultural, environmental, behavioral, and biological determinants of health and well-being
- Ensuring that health promotion action is beneficial and causes no harm
- Being honest about what health promotion is, and what it can and cannot achieve
- Seeking the best available information and evidence needed to implement effective policies and programs that influence health
• Collaboration and partnership as the basis for health promotion action
• The empowerment of individuals and groups to build autonomy and self-respect as the basis for health promotion action
• Sustainable development and sustainable health promotion action
• Being accountable for the quality of one’s own practice and taking responsibility for maintaining and improving knowledge and skills

Knowledge Base Underpinning
Health Promotion Core Competencies

The core competencies require that a health promotion practitioner draws on a multidisciplinary knowledge base of the core concepts, principles, theory, and research of health promotion and its application in practice.

A health promotion practitioner is able to demonstrate knowledge of the following:

• The concepts, principles, and ethical values of health promotion as defined by the Ottawa Charter for Health Promotion (WHO, 1986) and subsequent charters and declarations
• The concepts of health equity, social justice, and health as a human right as the basis for health promotion action
• The determinants of health and their implications for health promotion action
• The impact of social and cultural diversity on health and health inequities and the implications for health promotion action
• Health promotion models and approaches that support empowerment, participation, partnership, and equity as the basis for health promotion action
• The current theories and evidence that underpin effective leadership, advocacy, and partnership building and their implications for health promotion action
• The current models and approaches of effective project and program management (including needs assessment, planning, implementation, and evaluation) and their application to health promotion action
• The evidence base and research methods, including qualitative and quantitative methods, required to inform and evaluate health promotion action
• The communication processes and current information technology required for effective health promotion action
• The systems, policies, and legislation that influence health and their relevance for health promotion

1. Enable Change

Enable individuals, groups, communities, and organizations to build capacity for health promotion action to improve health and reduce health inequities.

A health promotion practitioner is able to

1.1 Work collaboratively across sectors to influence the development of public policies that have a positive impact on health and reduce health inequities
1.2 Use health promotion approaches that support empowerment, participation, partnership, and equity to create environments and settings that promote health
1.3 Use community development approaches to strengthen community participation and ownership and build capacity for health promotion action
1.4 Facilitate the development of personal skills that will maintain and improve health
1.5 Work in collaboration with key stakeholders to reorient health and other services to promote health and reduce health inequities

2. Advocate for Health

Advocate with, and on behalf, of individuals, communities, and organizations to improve health and well-being and build capacity for health promotion action.

A health promotion practitioner is able to

2.1 Use advocacy strategies and techniques that reflect health promotion principles
2.2 Engage with and influence key stakeholders to develop and sustain health promotion action
2.3 Raise awareness of and influence public opinion on health issues
2.4 Advocate across sectors for the development of policies, guidelines, and procedures across all sectors that have a positive impact on health and reduce health inequities
2.5 Facilitate communities and groups to articulate their needs and advocate for the resources and capacities required for health promotion action

3. Mediate Through Partnership

Work collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion action.

A health promotion practitioner is able to

3.1 Engage partners from different sectors to actively contribute to health promotion action
3.2 Facilitate effective partnership working that reflects health promotion values and principles
3.3 Build successful partnership through collaborative working, mediating between different sectoral interests
3.4 Facilitate the development and sustainability of coalitions and networks for health promotion action

4. Communication
Communicate health promotion action effectively, using appropriate techniques and technologies for diverse audiences.
A health promotion practitioner is able to

4.1 Use effective communication skills including written, verbal, nonverbal, and listening skills
4.2 Use information technology and other media to receive and disseminate health promotion information
4.3 Use culturally appropriate communication methods and techniques for specific groups and settings
4.4 Use interpersonal communication and groupwork skills to facilitate individuals, groups, communities, and organizations to improve health and reduce health inequities

5. Leadership
Contribute to the development of a shared vision and strategic direction for health promotion action.
A health promotion practitioner is able to

5.1 Work with stakeholders to agree a shared vision and strategic direction for health promotion action
5.2 Use leadership skills that facilitate empowerment and participation (including teamwork, negotiation, motivation, conflict resolution, decision making, facilitation, and problem solving)
5.3 Network with and motivate stakeholders in leading change to improve health and reduce inequities
5.4 Incorporate new knowledge to improve practice and respond to emerging challenges in health promotion
5.5 Contribute to mobilizing and managing resources for health promotion action
5.6 Contribute to team and organizational learning to advance health promotion action

6. Assessment
Conduct assessment of needs and assets in partnership with stakeholders, in the context of the political, economic, social, cultural, environmental, behavioral, and biological determinants that promote or compromise health.
A health promotion practitioner is able to

6.1 Use participatory methods to engage stakeholders in the assessment process
6.2 Use a variety of assessment methods including quantitative and qualitative research methods
6.3 Collect, review, and appraise relevant data, information, and literature to inform health promotion action
6.4 Identify the determinants of health that affect health promotion action
6.5 Identify the health needs, existing assets, and resources relevant to health promotion action
6.6 Use culturally and ethically appropriate assessment approaches
6.7 Identify priorities for health promotion action in partnership with stakeholders, based on best available evidence and ethical values

7. Planning
Develop measurable health promotion goals and objectives based on assessment of needs and assets in partnership with stakeholders.
A health promotion practitioner is able to

7.1 Mobilize, support, and engage the participation of stakeholders in planning health promotion action
7.2 Use current models and systematic approaches for planning health promotion action
7.3 Develop a feasible action plan within resource constraints and with reference to existing needs and assets
7.4 Develop and communicate appropriate, realistic, and measurable goals and objectives for health promotion action
7.5 Identify appropriate health promotion strategies to achieve agreed goals and objectives

8. Implementation
Implement effective and efficient, culturally sensitive, and ethical health promotion action in partnership with stakeholders.
A health promotion practitioner is able to

8.1 Use ethical, empowering, culturally appropriate, and participatory processes to implement health promotion action
8.2 Develop, pilot, and use appropriate resources and materials
8.3 Manage the resources needed for effective implementation of planned action
8.4 Facilitate program sustainability and stakeholder ownership of health promotion action through ongoing consultation and collaboration
8.5 Monitor the quality of the implementation process in relation to agreed goals and objectives for health promotion action

9. Evaluation and Research
Use appropriate evaluation and research methods, in partnership with stakeholders, to determine the reach, impact, and effectiveness of health promotion action.
A health promotion practitioner is able to

9.1 Identify and use appropriate health promotion evaluation tools and research methods
9.2 Integrate evaluation into the planning and implementation of all health promotion action
9.3 Use evaluation findings to refine and improve health promotion action
9.4 Use research and evidence-based strategies to inform practice
9.5 Contribute to the development and dissemination of health promotion evaluation and research processes

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Authors’ Note

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Notes

1. In this article, the term “Europe” refers specifically to the Member States and Candidate Countries of the European Union (EU) and the Members States of the European Free Trade Association (EFTA).
2. Including, for example, public health, health education, and social sciences, including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, and political science. This is not an exclusive list and other academic qualifications may also be deemed appropriate. It is recognized that there are practitioners in the field without a formal qualification and for these the CompHP Core Competencies provide a framework for assessing, and achieving formal recognition of relevant past experience.

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