Report

Developing a European Consensus on Core Competencies for Health Promotion

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Deliverable Number: 6
Workpackage Number: 4
March 2011
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Acknowledgements

The authors would like to extend a special thanks to all the health promotion professionals across Europe who have given so generously of their time and expertise in contributing to the Delphi process, the focus groups and online consultations.

We would also like to acknowledge the contribution of the CompHP Partners who reviewed and commented on each stage of the development of The CompHP Core Competencies Framework for Health Promotion Handbook. We would also like to thank the International Expert Advisory Group who provided very valuable insights, guidance and support to the development process of these competencies.

Thank you to Naoimh McMahon, MA student in Health Promotion, for her help with the online consultation and the tables.

Finally we would like to thank the Executive Agency for Health and Consumers who provided the funding for the CompHP Project.

This document arises from the project Developing competencies and professional standards for health promotion capacity building in Europe (CompHP – project number 20081209) which has received funding from the European Union, in the framework of the Health Programme. This publication has been produced under the contract with the Executive Agency for Health and Consumers. Its content is the sole responsibility of the authors and can in no way be taken to reflect the views of the Executive Agency for Health and Consumers or any other body of the European Union.
EXECUTIVE SUMMARY

This report details the work carried out by Workpackage 4\(^1\) of the CompHP Project ‘Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe (CompHP). The CompHP Project aims to identify, agree and publish core competencies for health promotion practice, education and training in Europe. The aim of Workpackage 4 was to develop consensus on core competencies for Health Promotion in Europe through the following methods:

- A review of the international and European literature on health promotion competencies
- An initial draft framework of core competencies based on findings from the literature review and consultation with CompHP Project Partners
- A Delphi survey on the draft core competencies undertaken with health promotion experts from across Europe to reach consensus
- Focus groups with health promotion experts and other key stakeholders from across Europe
- Consultation with health promotion stakeholders across Europe using a web based consultation process.

This report provides:

1. An overview of the international and European literature published on the development of competencies for health promotion, with reference to work in the related fields of public health and health education. This overview focuses particularly on the methodologies and processes used in the development of health promotion competencies internationally.

2. An outline of how the literature review informed the development of the CompHP Core Competencies for Health Promotion Framework.

3. A summary of the research processes through which consensus on the core competencies was developed with Health Promotion experts in Europe, leading to the publication of the CompHP Core Competencies for Health Promotion Framework Handbook.

INTRODUCTION

Background to the CompHP Project

The CompHP Project, which is funded by the Executive Agency for Health and Consumers (EAHC), 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 CompHP 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 24 European partners with experience across the professional development, policy, practice and academic sectors, CompHP 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). The work of CompHP is also supported by an International Advisory Group of experts with experience of the development of health promotion competencies at a global level. (See Appendix 1 for a full list of CompHP partners and members of the International Expert Advisory Group).

The CompHP Project 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 (2007-2010), sought to develop a pan-European competency framework for health promotion. The CompHP Project was informed by a Europe-wide scoping study (1) and feasibility study (2) 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 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 (3,4). 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 (5,6,7,8).

The European Context

Out of the 47 European countries, 27 countries are members of the European Union with three other European countries described as candidate countries. 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 Europe², ³.

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 (9). This has an important impact on the need for, and the focus of, core competencies for health promotion in Europe.

³ http://ec.europa.eu/health-eu/health_in_the_eu/index_en.htm
The European Health Strategy, *Together for Health: a strategic approach for the EU 2009-2013* 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. The European Health Strategy 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.

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 strategic 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. Member states can benefit from a system that facilitates structured exchange, collaboration and coherence across diverse national structures in building the capacity of the health promotion workforce.

In view of the different stages of health promotion development across Europe, 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.

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 standards is necessary for the ethical use of resources and effective action on health.

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5 http://ec.europa.eu/index_en.htm
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\(^6,7\) 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 (10). These strategies and treaties, therefore, provide a powerful background context for the development of pan-European competencies for health promotion.

Health promotion in Europe is an evolving field with a diverse and growing workforce drawn from a range of disciplines, and operating in a variety of settings and across a wide range of political, economic and social contexts. Given this diversity, it was identified that there was a need for core competencies which delineate the specific body of skills, knowledge and expertise that represents, and is distinctive to, health promotion practice, to unify and strengthen health promotion workforce capacity across Europe (3,4).

**Capacity Building 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 (11).

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” (12). 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

\(^6\) http://ec.europa.eu/internal_market/qualifications/policy_developments/legislation_en.htm

what infrastructure is required for the sustainable implementation of effective practice for the future (6). Global interest in workforce development, capacity building, and quality assurance in health promotion and education has increased during the past decade (3). Improving the quality of health promotion practice is at the core of this interest (4,13).

Barry (6) identified two priority areas for action in the IUHPE Vice President for Capacity Building, Education and Training workplan (2008):

- 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 (6,14).

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 21st century (3,4,13). 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 (7).

**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. Core competency development is widely used in workforce initiatives to identify the essential elements for effective performance.
What are Core Competencies?

The definition of competencies agreed by the CompHP Project Partners for use in the project was adapted from Shilton (15): "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".

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 (16). 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 (17) and subsequent World Health Organisation (WHO) declarations (8,18,19,20,21,22).

The term ‘core competencies’ as used in the CompHP Project refers to: “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” (23).

How can the CompHP Core Competencies be used?

The purpose of health promotion competencies is to provide a description of the essential knowledge, abilities, skills and values that are needed to inform effective practice. In this context some countries or organisations may use the CompHP Core Competencies Framework as a standalone document. However, within the context of the CompHP Project the core competencies are designed to provide a base of knowledge and skills for practice that will inform the development of Professional Standards for Health Promotion and a pan-European Accreditation Framework. An effective competency framework provides a solid base for workforce development and has a wide range of potential useful applications across many areas.

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8 Currently being developed as part of the CompHP Project
The CompHP Core Competencies have a key role to play in developing health promotion capacity by (24):

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

Core Competencies may promote 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
- Forming the basis for accountable practice and quality assurance.

Core Competencies can benefit health promotion practitioners by:

- Ensuring that there are clear guidelines for the knowledge, skills and values needed to practice effectively and ethically
- Informing education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs
- Assisting in career planning and identifying professional development and training needs
- Facilitating movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies
- Promoting better communication and team work in multidisciplinary and multisectoral settings by providing a common language and shared understanding of the key concepts and practices used in health promotion
- Helping to create a more unified workforce by providing a shared understanding of key concepts and practices
- Contributing to greater recognition and validation of health promotion and the work done by health promotion practitioners.
Core Competencies can benefit health promotion organisations by:

- Identifying staff development and training needs
- Developing job descriptions, interview questions and frameworks for evaluation and quality assurance
- Identifying the appropriate numbers and mix of health promotion workers in a given setting
- Assisting employers and managers to gain a better understanding of health promotion roles in individual workplaces and develop appropriate job descriptions.

**Core Concepts and Principles Underpinning the CompHP Core Competencies**

The competencies are based on the core concepts and principles of health promotion outlined in the Ottawa Charter (17) and successive WHO charters and declarations on health promotion (8,18,19,20,21,22). Health promotion is, therefore, understood to be ‘the process of enabling people to increase control over, and to improve, their health’ (17). Health promotion is viewed as representing a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also actions directed toward changing social, environmental and economic conditions which impact on health (25). Health is defined as ‘a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity’ (26). Health is further conceptualized as a resource for everyday life, emphasizing social and personal resources, as well as physical capacities (17).

The CompHP Core Competencies are underpinned by an understanding that health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (27,28) and that there are well-developed theories, strategies, evidence and values that underpin good practice in health promotion (29).
Development of the CompHP Core Competencies

The key elements in the development process for the CompHP Core Competency Framework for Health Promotion were:

- A review of the international and European literature on health promotion competencies
- An initial draft framework of core competencies based on findings from the literature review and consultation with CompHP Project Partners
- A Delphi survey on the draft core competencies undertaken with health promotion experts from across Europe to reach consensus
- Focus groups with health promotion experts and other key stakeholders from across Europe
- Consultation with health promotion stakeholders across Europe using a web based consultation process.

The CompHP Project Partners and the International Expert Advisory Group advised on each stage of the development process.

Each of these development stages will now be discussed.

LITERATURE REVIEW

A preliminary review of the international literature on competency development indicated that competency development initiatives frequently used a review of the literature as a starting point. From a European health promotion perspective one of the challenges facing pan-European competency development was the differences in terminology, titles and job descriptions across Europe. As the core work of the CompHP Project was to develop core competencies for health promotion, it was agreed that the best starting point was to carry out an extensive review of the literature, encompassing both European and Global development.
The aim of this review was to carry out an extensive review of all the European and international literature, both published and unpublished. This review had two broad functions:

- To identify published competency frameworks which could inform the development of a CompHP framework
- To examine the various methodologies and processes used in the development of existing competency frameworks.

The literature review thus provided 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 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 were also reviewed as the context for identifying and agreeing core competencies. Contextual and critical issues arising in this field of work were outlined and discussed.

The review focused on the international literature on competencies published between 1900 and 2009. Unpublished documents available in English or which were made available in English from a number of European countries were also reviewed. While undertaking the review it was decided to expand the scope of the information gathering (and the research processes in later stages) to include a total of 34 European countries.

While the focus within the CompHP Project is on health promotion as defined in the Ottawa Charter (17) it was considered necessary to refer also to public health and health education literature when exploring policy, practice and education in a pan-European setting and in reviewing competency development globally. This was necessary 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 practice, while officially referred to as ‘public health’ or health education’.
The review commenced in September 2009 and drew 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. Literature sources were found through a search of online databases including the following:

- Cochrane Library
- Centre for Disease Control (CDC)
- Google Scholar
- Medline
- 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

The terms used to guide the search and criteria for inclusion in the review included:

- Health promotion competencies
- Public health competencies
- Health education competencies
- Capacity building in health promotion
- Health promotion in ‘country’
- Developing professional competencies
- Developing professional standards
To supplement the online search for published material, the CompHP Project Partners were asked to submit any literature from their country, both published and unpublished, on the development of health promotion competencies and other related topics within the search criteria. Contacts from other European Union (EU) countries not represented by a partner in the CompHP Project were identified either through HP-Net, previously published material or previous participation in the development of health promotion and/or public health competencies. The contacts identified were also asked to submit any literature relevant to health promotion competencies and other issues within the search criteria.

Findings from Literature Review

Existing Competency Frameworks

This review clearly showed that there is an emerging international literature on the competencies required for health promotion practice. A number of countries have made significant progress in delineating competencies for health promotion (7), including Canada (30,31,32,33), Australia (15,23,34,35,36,37), New Zealand (38,39,40) and a number of countries in Europe (1,10,41), including the UK (42,43,44,45,46), the Netherlands and Estonia (10). Some exploration of competencies has also been undertaken in EU funded projects such as the European Masters in Health Promotion project (EUMAHP) (47,48,49,50) and PHETICE (Public Health Education in the Context of an Enlarging Europe)10. ASPHER (The Association of Schools of Public Health in the European Region)11 is currently developing standards for public health practice which incorporate a health promotion competency subset.

Significant developments have also taken place in the USA, mainly focusing on health education (51,52,53) and related accreditation systems ((54,55). In Europe, accreditation systems have been developed in the UK (45,46), 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 (3,4) adds a global perspective

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9 http://www.hp-source.net/
10 http://www.phetice.org
11 http://www.aspher.org
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.

**Methodologies Used for Developing Competencies**

This literature review demonstrated a range of different methods in developing lists of competencies and the processes used in reaching consensus on them across relevant stakeholders. These included literature reviews, consultations with practitioners, questionnaires, focus groups and the Delphi process. Although differences emerged in the methods used, many common elements were identified and these will now be discussed.

A literature review was found to be the most commonly used starting point (32,33,35,36, 40,43,44,56). A literature review informs not only the approaches used in relation to developing the competencies but can also give important information on the relevant health promotion workforce and setting. This is important as countries with similar systems to those discussed can benefit from flaws or gaps identified in previous studies in their approaches to developing competencies. In addition, a literature review enhances 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 were an element of the development process identified as important in the literature. Moloughney (33), for example advises highlighting items of particular importance for further description and advises asking the following 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?

It was noted in the literature that at this stage some may decide to carry out an information gathering exercise. The purpose of this exercise is to focus on what actually happens in
practice within the specific context. This exercise can use a variety of approaches but all involve some form of consultation such as workshops which were used in the UK or think tanks as in New Zealand. In the USA the approach involved observing or interviewing or both an ‘exemplary’ practitioner to identify the actions, content and context involved in their ‘exemplary practice (57).

In the competency development process, questionnaires are frequently used both for gathering information (47,48,49,50) and in surveying opinion on draft frameworks (15,35,36). Other examples included the ASPHER project which invited schools of public health to submit lists of competencies that they felt were important (58). Other initiatives undertook surveys of a representative sample of practicing professionals to determine what they actually do in practice (43,44,52).

Mapping exercises have also been used (43,44,50) where mapping the domains and competencies was used to identify what are considered to be core competencies for practice. Functional analysis has also been used in developing competencies (45,46). This process involves identifying the core functions of a group or organisation which are used to form a ‘map’, and key tasks are then identified through in-depth interviews or focus groups. 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 (59).

Drawing up a set of draft competencies is identified in the literature as usually being the next stage and may include a discussion paper as in New Zealand. When a draft has been developed it is 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 Canada, Australia and Scotland the consultation process used questionnaires (30,37,43), while focus groups were used in the USA (52), ‘think tanks’ were employed in New Zealand (40) and workshops in ASPHER (58,59,60). 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 was noted as being commonly used, for example, in the competency frameworks developed in Canada and Australia (31,34,36,37). The Delphi method attempts to obtain expert opinion and information in a systematic manner where participants are polled individually usually with a self-administered questionnaire (61). This entails a multi-stage process where questions are posed, the results are analysed and then reported back to the group. A Delphi is considered complete when there is a convergence of opinion or when a point of diminishing returns is reached (61) or, as in the case of the CompHP Project, an agreed ‘consensus point’ has been reached.

All consultations reported in the literature used multiple rounds of consultation to ensure the widest scope of feedback possible. The feedback from the overall consultation process is then analysed and the findings are used to prepare a final draft of the competencies which is disseminated for final ratification. However, many authors note that 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 of health promotion 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 with the involvement of the professionals who have to demonstrate competence on a daily basis in their work (58) 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’ (7).

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., (62) 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 (15) and the importance of grounding competencies in current policy has also been highlighted (43,44).

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 (58).

Meresman et al., (50) 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 (57).

The literature review demonstrated the many approaches that can be applied to the development of competency frameworks and that, while a variety of approaches were used no one method was replicated exactly. However, there is agreement across the various sources reviewed 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. It was also generally agreed that the competency development process needs to be rigorous, systematic and inclusive and firmly grounded in the core principles and practice of health promotion. 12

12: The CompHP Literature Review Developing Competencies for Health Promotion can be downloaded at: http://www.iuhpe.org/uploaded/Activities/Cap_building/CompHP/CompHP_LiteratureReviewPart1.pdf
METHODOLOGY FOR COMPETENCY DEVELOPMENT IN THE COMPHP PROJECT

Methodology employed for the CompHP Competency Development

Based on the Literature Review it was decided that the best approach to achieving consensus in competency development was to employ a multiple-method layered approach, incorporating as broad a base of feedback as possible in order to capture the complexities of health promotion in the European context. These will now be described.

Mapping the Competencies

Mapping involves the construction of a visual framework that helps to understand relationships (or assumed relationships) among the many factors that contribute to or detract from capacity and, ultimately, performance. Mapping can be used to identify untapped, constrained, or missing elements of capacity (63). Mapping exercises have been used in the context of health promotion (43,44,49,50).

The Galway Consensus Statement on domains of core competencies in health promotion (3) was seen as providing a useful overall framework for European developments. The statement was the outcome of a conference held in 2008 where a group of health promotion experts agreed the core domains necessary for health promotion practice at a global level.

The eight domains of core competency identified in the Statement are:

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.

As the next step in the mapping process, health promotion competencies identified from the international and European literature were analysed for content and matched with the appropriate core domain as identified in the Galway Consensus Statement. Two themes which were common across all the other frameworks reviewed, and which were also highlighted in the global consultation which followed the publication of the Galway Consensus Statement, were added to the first draft of the CompHP Core Competencies Framework, namely Communication and Knowledge.

**Commonalities across Frameworks**

Table 1 presents the main themes that emerged from the different competency frameworks reviewed. 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 complied internationally and in Europe.
The intersectoral, collaborative and multidisciplinary nature of health promotion was evident in the range of varied competency frameworks 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, differences between the frameworks were to be expected. Despite the differences, 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 were apparent across the frameworks. There was some variation in how some competencies were identified as ‘core’ or as a full domain while in other frameworks the same competencies were considered subsumed within a broader domain. For example, in the New Zealand framework (38) partnership and collaboration were identified as competencies within the domain of programme/project planning, differing from others such as the Australian (23) and Canadian (30,31) approaches. Some frameworks include planning, implementation and evaluation as one core domain, while others considered each as a separate domain. Communication was a key domain in most frameworks, but, as noted had not been identified as a core domain in the Galway Consensus Statement (3).

In developing the first draft of the CompHP Core Competencies, the term ‘catalyzing change’, which was used as the first core domain in the Galway Consensus Statement, was changed to incorporate a broader understanding of enabling change/empowerment and was renamed ‘Enabling Change’.

The principal domains identified for the initial draft were: needs assessment, planning, evaluation, advocacy, partnership/collaboration, and communication. The themes of social justice, equity, equality, and cultural diversity were considered to be evident through much of the competencies identified but were not specifically identified as competencies in this first draft. It was noted, however, that the New Zealand Competencies Framework (38)
does include a specific cluster of competencies on cultural diversity and that in Australia
cultural competencies for have been developed\textsuperscript{13} although they are not directly linked to
the health promotion competencies. Other frameworks such as Australia (23), UK (42),
Scotland (43,44) and Israel (56) address cultural diversity in some of the competency
statements.

The ethical dimension of health promotion is evident in the Ottawa Charter (17) and this is a
common theme reflected in the health promotion 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 (43,44).

Other themes identified from competencies that were not reflected in the eight core
domains were Communication and Knowledge. The table developed was used as the basis
for the main mapping exercise where individual competency statements were mapped in a
more expansive way according to their theme/domain (See Appendix 2 - Table 5: Map of
Competencies).

\textsuperscript{13} \url{www.ceh.org.au}
<table>
<thead>
<tr>
<th>Core Domains</th>
<th>Aus</th>
<th>NZ</th>
<th>Canada</th>
<th>USA</th>
<th>UK</th>
<th>Scotland</th>
<th>GCS</th>
<th>ASPHER</th>
<th>PHETICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catalyzing Change</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leadership/management</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needs Assessment</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning/development of evidence based programmes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Implementation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Evaluation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Advocacy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership/collaboration</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cultural understanding, relevance and sensitivity</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethics</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inequality / equity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Technology</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge (Health promotion models, theory, research and policy)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
</tbody>
</table>
DEVELOPMENT OF THE FIRST DRAFT FRAMEWORK

Using the Ottawa Charter as a guide the content of this Competency Map was then analysed further. Sub themes were identified and categorised according to the 10 core domains and were refined further until the first draft of 10 core domains and 79 core competencies were identified. An introduction which gave the background to the CompHP Project and the development of the core competencies, definitions of health promotion and a glossary of terms used in the framework completed the CompHP Core Competencies for Health Promotion Draft 1 (See Appendix 3).

The Instruments used in the Consensus Building Process

The CompHP Project aims to achieve consensus from experts in health promotion across Europe. For the purpose of the CompHP Project consensus was defined as meaning overwhelming agreement. The key indicator of whether or not a consensus has been reached is that everyone agrees they can live with the final proposal after every effort has been made to meet any outstanding interests. Most consensus processes seek unanimity, but settle for overwhelming agreement that goes as far as possible toward meeting the interests of all stakeholders (85). It was agreed that for the purposes of the CompHP Project consensus would be defined on a statistical basis where a mean score of 3.5 or more would be a consensus point for retaining a domain or competency statement. This is discussed in more detail under ‘Data Analysis’.

The findings from the literature review (86) informed the development of the instruments and the processes used in order to collect data and build consensus. One of the logistical challenges facing the workgroup was to try to overcome difficulties of achieving consensus with a group of stakeholders spread across a wide geographic area, working within different political and cultural contexts, and differing levels of development in health promotion. As the Delphi method allows for the collection of a large number of responses over a substantial geographical area, in a relatively short period of time (61), it was considered to be the most appropriate technique to build consensus within the project timeframe. A
questionnaire based on the Competency Framework was developed as the Delphi survey instrument and ‘Survey Monkey’\textsuperscript{14} used as the data collection tool.

**Rationale for using the Delphi Process**

The Delphi Process is used to collect and distil the judgments of experts using a series of questionnaires interspersed with feedback (64). Evans (65), cited in Keeney (66), says that at present there are no formal, universally agreed guidelines on the use of the Delphi technique nor does any standardisation of the methodology exist. The Delphi process as a methodology was considered to be particularly useful in helping overcome the logistical problems identified in relation to developing core competencies across Europe. For example, Jariath and Weinstein, (67) stated that one of the reasons for the popularity of the Delphi method is the fact that it allows the inclusion of a large number of individuals across diverse locations and expertise and helps avoid the situation where a specific expert might be anticipated to dominate the consensus process. According to Thompson (68) when experts are located over a wide area, the Delphi method can easily and cost effectively embrace a geographically dispersed sample.

Another reason for using the Delphi method is that it takes time to gain consensus in face-to-face meetings, as well as the fact that such meeting may result in the opinions of a few influential people being heard while the views of the more reticent may not be heard thus incorporating the opinions of all the participants (69).

One of the basic principles of the Delphi technique is to use as many rounds of surveys as are required to achieve consensus or until the ‘law of diminishing returns’ occurs. In order to gather and to revise responses obviously requires that the there be at least two rounds. Although there are no strict guidelines on the correct number of rounds, the number can depend upon the time available and whether the project manager began the Delphi process with one broad question or with a list of questions or events (66).

\textsuperscript{14} http://www.surveymonkey.com/
Starkweather et al., (70), cited in Keeney (66) said that the number of rounds can be decreased from that planned if there is a reduction in the amount of new information and in numbers of responses identified as probably resulting from respondent fatigue. For example, McKenna (71) considered that response exhaustion occurred after two rounds, especially with busy ‘experts’ and hard-pressed clinicians. According to Keeney et al., (66) generally, questionnaires are notorious for low response rates and two or three reminders to non-responders are common.

The literature indicates that the Delphi process can involve anything from two to four rounds of questionnaires (66,68,72,75). In addition to differing in the number of rounds in a Delphi survey, there are also differences noted in the literature in relation to the starting point. For example, the content of the first round can be based on findings from the literature (72,73,74,75), or can pose an open question where participants identify the key points for further exploration in the repeated rounds. For the purpose of the CompHP Project, it was agreed to base the first round of the Delphi survey on the draft Core Competencies Framework derived from the literature. As the Delphi process is time consuming and after fully considering the literature on methodology, response rates and respondent fatigue, it was decided that as respondents were being presented with a set of competency statements that two rounds of Delphi would be sufficient to achieve consensus (see also Data Analysis).

Data Collection
Given the geographical spread of the intended respondents it was important to consider how best to collect the data for the Delphi survey. The use of an online survey was identified as being most appropriate for the Delphi survey on core competencies. Web based surveys are becoming increasingly popular as, compared to traditional mail surveys, they allow researchers to quickly and easily design and implement surveys and collect participant responses (76,77). Online surveys also allow researchers to reach many people in a short amount of time across great geographical distances (78), a key consideration for the CompHP Project. The use of an online survey is also credited with saving money by
eliminating the need for paper and other costs, such as postage, printing, and data entry (78).

As the Survey Monkey online survey tool had already been used for competency development (36), it was decided to use it for the CompHP Delphi survey.

**Development of the CompHP Delphi Survey Questionnaire**

After the first draft of the competency framework was completed and had been reviewed by the CompHP Project Partners and the International Expert Advisory Group, a questionnaire was developed which was divided into three sections and contained a total of 123 questions.

The first section of the questionnaire comprised three general questions on the Introduction and Background to the Draft 1 Framework Document. The second section contained a total of 100 questions, each of which was concerned with a specific domain and its associated competency statement. Participants were asked to rate their level of agreement with each domain/competency statement using a 5-point Likert Scale which was designed to allow for calculation of means in the analysis stage. (See Figure 1 below).

*Enabling change and empowering individuals and communities to improve their health*

<table>
<thead>
<tr>
<th>Do you agree that this domain is core to health promotion practice</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

*Figure 1: Sample Likert Scale question*

Each question also included a comment box where respondents were invited to make comments on any changes, suggestions, improvements etc to the domain/competency statement.

The final section posed general questions on the uses of the framework and demographic data. This section comprised a mixture of rated questions and open ended questions that allowed for general comment. Respondents were also asked if there were any domains or competencies that should be removed from or added to the framework.
Finally, the questionnaire contained questions on the potential uses of the framework and its relevance to and reflection of practice in the respondent’s country. For the first round of the Delphi survey, questions on respondents’ interest in participating in focus groups scheduled to be held at the 20th IUHPE World Conference on Health Promotion: Health, Equity & Sustainable Development in Geneva in July 2010, were also included.

Data Analysis

The literature review also informed the data analysis. Initially, the rationale that guided the decision to keep or remove any domains or competencies was based on achieving a mean score of 3.5 or more.

Hasson et al., (72) acknowledges there is no universal agreement on what level of consensus should be employed for use in the Delphi process. Using a 5 point Likert scale Rigatto Witt and Puntel del Almeida (79) set the level of consensus at 75% for a score of 4 (Agree) and 5 (Strongly Agree). Green (80) cited in Hsu (75), suggests that at least 70% of Delphi subjects need to rate three or higher on a four point Likert-type scale. Other authors suggest consensus could be equated with 51% (81), while Sumision (82) recommends 70%, and Green et al., (83) opted for 80%. In the U.S. the development of the CUP was guided by using a mean score of 3 on a four point scale (55).

Based on these findings, together with agreement from the International Expert Advisory Group and the CompHP partners, it was decided that 70% of the respondents should score 3.5 or more for inclusion to be valid and considered to be consensus.

The mean result for each domain and competency statement would thus provide the first level of analysis and agreement. The respondents were also asked to suggest changes and indicate if the domains or competencies in the draft should be removed or new ones added. In the research design the feedback received from these questions would be analysed for content and the findings considered, together with the mean score, to decide to retain, remove or modify the domains or competency statements.
**Pilot Study**

The 1st Draft of the Framework Document and the questionnaire was piloted with the CompHP Project Partners and the International Expert Advisory Group (n=19). The response rate was 68% (n=13). Draft 1 of the framework document was then modified based on the feedback received. In addition, some minor changes which had been suggested were made to the questionnaire to aid clarity and to enhance the data collection process. The full analysis of the pilot process, including the feedback and the actions based upon it can be seen in Appendix 4 (Table 6: Result from the Pilot Study). The modified framework document was renamed ‘CompHP Core Competencies for Health Promotion Draft 2’ (See Appendix3).

**Identifying the Sample for the Delphi Consensus Building Process**

The sample for the Delphi process was selected according to the following criteria:

- Representatives from all 33 relevant countries (27 EU member states, 3 Accession states, 3 EETA countries and Switzerland)
- Two representatives with expertise in health promotion from each of the areas of policy, practice, education and training in each country
- Representatives with experience in the competency approach.

The source for the sample frame was the CompHP Stakeholders List, which is based on an exhaustive search of health promotion contacts and networks across Europe, as identified by WP2 project partners. A total of 204 participants were originally targeted for inclusion in the survey.

**Sampling process**

Step 1: Information from the Stakeholder List was analysed by the WP 4 (Developing Competencies) research team using the criteria above to ensure that there were a sufficient number of representatives within each of the three categories in each of the relevant countries. Where the analysis shows that there are some countries where a sufficient number of stakeholders under each of the three categories had not been identified the team implemented Step 2.
Step 2: The WP 4 research team identified a key stakeholder in the countries with less than the required number of participants and contacted them to ask for nominations of health promotion specialists with the required expertise to complete the sample. It was recognised that in some countries where health promotion is less well developed it may not be possible to identify the target of two representatives under each of the agreed categories and that, therefore, the final total may be less than 204.

Step 3: When a sufficient sample of participants under each heading was identified, the individual participants were selected using a random selection process. This entailed selecting the academic, practice and policy participants in the order in which they appeared on the Stakeholder List. The final number of participants identified was 180 (See Table 2 below).

Table 2: Identified Delphi Participants by Country

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austria</td>
<td>6</td>
</tr>
<tr>
<td>Belgium</td>
<td>6</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>5</td>
</tr>
<tr>
<td>Croatia</td>
<td>6</td>
</tr>
<tr>
<td>Cyprus</td>
<td>3</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>6</td>
</tr>
<tr>
<td>Denmark</td>
<td>6</td>
</tr>
<tr>
<td>Estonia</td>
<td>6</td>
</tr>
<tr>
<td>Finland</td>
<td>6</td>
</tr>
<tr>
<td>France</td>
<td>6</td>
</tr>
<tr>
<td>Germany</td>
<td>6</td>
</tr>
<tr>
<td>Greece</td>
<td>3</td>
</tr>
<tr>
<td>Hungary</td>
<td>6</td>
</tr>
<tr>
<td>Iceland</td>
<td>6</td>
</tr>
<tr>
<td>Ireland</td>
<td>6</td>
</tr>
<tr>
<td>Italy</td>
<td>6</td>
</tr>
<tr>
<td>Latvia</td>
<td>6</td>
</tr>
<tr>
<td>Lithuania</td>
<td>6</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>1</td>
</tr>
<tr>
<td>Malta</td>
<td>6</td>
</tr>
<tr>
<td>Netherlands</td>
<td>6</td>
</tr>
<tr>
<td>Norway</td>
<td>6</td>
</tr>
<tr>
<td>Poland</td>
<td>6</td>
</tr>
<tr>
<td>Portugal</td>
<td>6</td>
</tr>
<tr>
<td>Republic of Macedonia</td>
<td>3</td>
</tr>
<tr>
<td>Romania</td>
<td>6</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>6</td>
</tr>
<tr>
<td>Slovenia</td>
<td>6</td>
</tr>
<tr>
<td>Spain</td>
<td>6</td>
</tr>
<tr>
<td>Sweden</td>
<td>6</td>
</tr>
<tr>
<td>Switzerland</td>
<td>6</td>
</tr>
<tr>
<td>Turkey</td>
<td>3</td>
</tr>
<tr>
<td>UK</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td><strong>180</strong></td>
</tr>
</tbody>
</table>
First Round of Delphi Survey

In the first round of Delphi survey the questionnaire was sent to 180 people from across Europe (See Table 2 above). Participants were sent an invitation to participate by email with a link to the Survey Monkey questionnaire. The CompHP Core Competencies for Health Promotion Draft 2 framework document and a PDF of the questionnaire were sent as attachments to the email. Initially responses were slow to return and the deadline for replies was extended twice to maximise the response rate.

Analysis of Round 1

The total response from Round 1 was n=81 (45%). A total of 30 countries responded. The responses were added to the responses received from the pilot and the results below reflect the responses from the combined total (n=94). Means and percentages were calculated on the responses to each question. The domains identified in the daft document scored a mean rating from 4.43 to 4.62 (see Table 3 below) and the competency statements scored mean ratings from 4.19 to 4.60 (See Appendix 4: Table 7, for full scores and feedback).

<table>
<thead>
<tr>
<th>Domain</th>
<th>Mean</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enabling Change</td>
<td>4.49</td>
<td>95.5%</td>
</tr>
<tr>
<td>Leadership</td>
<td>4.52</td>
<td>95.4%</td>
</tr>
<tr>
<td>Assessment</td>
<td>4.57</td>
<td>95.4%</td>
</tr>
<tr>
<td>Planning</td>
<td>4.52</td>
<td>94.2%</td>
</tr>
<tr>
<td>Implementation</td>
<td>4.46</td>
<td>95.3%</td>
</tr>
<tr>
<td>Evaluation and Research</td>
<td>4.45</td>
<td>91.9%</td>
</tr>
<tr>
<td>Advocacy</td>
<td>4.43</td>
<td>93%</td>
</tr>
<tr>
<td>Partnership</td>
<td>4.60</td>
<td>97.7%</td>
</tr>
<tr>
<td>Communication</td>
<td>4.62</td>
<td>95.3%</td>
</tr>
<tr>
<td>Knowledge</td>
<td>4.44</td>
<td>93%</td>
</tr>
</tbody>
</table>

Respondents’ feedback and comments were also analysed and common issues and major themes identified. The key issues identified were used in conjunction with the mean scores to inform changes to the framework.

The main themes to emerge from the feedback were:

• Some overlap and repetition between domains and competencies
• Contents should be simplified
• Too many competencies
• Framework too idealistic and/or ambitious
• Some competencies set too high for entry level.

On the basis of the feedback and mean scores the framework was modified and the number of competencies reduced from 79 to 60. The domain of Partnerships was changed to ‘Mediate through Partnership’ to better reflect the action area identified in the Ottawa Charter and the order of domains was changed to what had been suggested as a more logical and sequential order:

1. Knowledge
2. Enable Change
3. Advocacy
4. Mediate through Partnership
5. Communication
6. Leadership
7. Needs Assessment
8. Planning
9. Implementation
10. Evaluation and Research

A graphic of the Competency Framework was developed to illustrate the domains and the relationship between them (See Figure 2 below).

Figure 2: Illustration of CompHP Competency Domains
The revised framework document ‘CompHP Core Competencies for Health Promotion Draft 3’ is available in Appendix 3. This draft of the Framework, together with the feedback received from the first round of Delphi was sent to the Project Partners and the International Advisory Group for further comment and the feedback and proposed changes were also discussed at a CompHP. Workpackage Leaders’ meeting in Sardinia in May 2010,

Second Round of Delphi
The same sample was used for the second round of the Delphi survey apart from a few respondents (n=7) who had indicated that they did not wish to participate further and whose names were, therefore, removed from the list. The Survey Monkey questionnaire was revised to reflect the changes made to the competency framework which resulted in a shorter questionnaire consisting of an electronic page or section for each of the domains and its associated competency statements and some general questions and demographic questions (as in Round 1). The revised questionnaire and the revised Draft 3 of the Framework was emailed to most of the original Delphi respondents (n=173) and some additional names that were nominated for Round 2 (n=7) and added to the list (n=180). The questionnaire was also sent to the CompHP Project Partners and the International Expert Advisory Group (n=19) were also in. A total of 199 were invited to contribute to Round 2.

Results of Round 2
Responses to Round 2 were again slow possibly due to a combination of factors including that fact that this round was active during the summer months when many respondents could be on annual leave, attending conferences etc. In recognition of this, the closing date for replies was extended twice to maximise the response. The total response of Round 2 was (n=61, 30.7% of the full sample). As with Round 1, means and percentages were calculated on the responses on the domains and competency statements. The domains identified in the draft document scored a mean rating from 4.42 to 4.66 (see Table 4 below) Means ranged from 3.87 to 4.68 for all domains and competencies. Feedback and comments were again considered with respect to each of the competency statements (Please see Appendix 4: Table 9, for full details on scores and feedback).
Table 4: Means and Percentages for Domains from Delphi Round 2

<table>
<thead>
<tr>
<th>Domain</th>
<th>Mean</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge</td>
<td>4.52</td>
<td>93.4%</td>
</tr>
<tr>
<td>Enable Change</td>
<td>4.60</td>
<td>96.7%</td>
</tr>
<tr>
<td>Advocacy</td>
<td>4.57</td>
<td>95%</td>
</tr>
<tr>
<td>Mediate through Partnership</td>
<td>4.52</td>
<td>(93.3%)</td>
</tr>
<tr>
<td>Communication</td>
<td>4.68</td>
<td>98.3%</td>
</tr>
<tr>
<td>Leadership</td>
<td>4.43</td>
<td>91.7%</td>
</tr>
<tr>
<td>Needs Assessment</td>
<td>4.42</td>
<td>86.7%</td>
</tr>
<tr>
<td>Planning</td>
<td>4.63</td>
<td>91.7%</td>
</tr>
<tr>
<td>Implementation</td>
<td>4.46</td>
<td>96.6%</td>
</tr>
<tr>
<td>Evaluation and Research</td>
<td>4.51</td>
<td>89.8%</td>
</tr>
</tbody>
</table>

Some of the main themes reflected in the comments included:

- Some overlap and repetition between domains and competencies
- Too long and needs to be simplified
- Too idealistic
- Levels need to be identified
- Knowledge domain more overarching
- Ethical values needed to be articulated clearly.

The key changes resulting from the qualitative findings were to the Leadership and Advocacy domains where the wording of the competencies was modified and the number of competencies reduced. (Please see Drafts 2 and Draft 3 of the Competency Framework in Appendix 3).

**Focus Groups**

In July 2010 the CompHP Project Partners presented a symposium at the 20th IUHPE World Conference on Health Promotion in Geneva. The opportunity also provided an opportunity to organise focus groups with, key stakeholders, partners and international experts. A total of 25 people participated. Participants from 17 European countries and six international experts contributed to the focus group discussions (Please see Appendix 5 for Focus Group Questions and Consent Form). Focus group feedback, in conjunction with the findings from the questionnaire, informed the development of Draft 4 of the CompHP Core Competencies Framework (See Appendix 3).
Feedback from Focus Groups

Overall the feedback was positive with respondents reporting that they were happy with the content of the framework. Some respondents reported that they felt that one of the big strengths of the CompHP Draft Framework was that it defined exactly what health promotion is, what the work of health promotion involves and what health promotion practitioners do. This can give the role of health promotion more clarity. When published, it was thought that the handbook could be used as a manual which could empower and facilitate the work of health promotion.

It was felt that the framework would be useful in a variety of settings and to a variety of professionals including academia, practitioners, employers and policy makers. Some of the uses identified included helping develop academic courses, job descriptions, and performance appraisal tools.

Some respondents felt that the framework was long and that there was some overlap between domains and competencies. While there was general consensus with the Knowledge Domain and its associated competency statements, some felt it did not quite fit with the other domains as it was more overarching in its nature. It was also felt that although ‘ethics and values’ were implied throughout the framework they needed to be more clearly articulated. Quite a lot of discussion centred on the issue of levels, where some respondents felt that some competencies may be too demanding but there was general consensus that all domains were necessary.

Some respondents suggested that the language be kept simple and clear to avoid any issues with translation as interpretations can vary from country to country. Overall, focus group participants were very positive regarding the Framework and felt that it was a useful tool to guide and support the work of health promotion practitioners into the future.
Combined feedback from Delphi Round 2 and the Focus Groups

Overall the feedback from both the questionnaire and focus groups was positive and that respondents considered the Framework to be a useful tool. Comments included the fact that the framework explained what health promotion was about and that it could be used as a manual which could empower and facilitate the work of health promotion. Some considered that that it would be most useful in academia, but it was also recognised as being useful for practitioners, employers and policy makers.

Some respondents again indicated that the Framework was too long and that there was some overlap in its contents. Although consensus was reached on all domains some comments were made regarding the Knowledge domain. While there was agreement that it was necessary, it was considered different because the knowledge base should underpin all the other domains. Another key area of comment regarding the domains, was that although ethics and values were discussed in the Introduction as being the basis for the Framework, that given the importance of ethics and values to health promotion practice, these needed to be more clearly articulated, perhaps as a separate domain or sub-domain.

Development of Draft 4

The mean scores and combined feedback from Round 2 of the Delphi process were considered with the focus groups feedback and it was decided to reconfigure the Framework by removing the Knowledge Domain as a core domain and adding it, together with a new domain on Ethical Values, as specific domains underpinning the nine other domains.

The Ethical Values Domain articulated in the Draft 4 of the Framework was based on a variety of sources including ethical values statements in the Competencies Frameworks from Australia and New Zealand and the Principles of Ethical Practice of Public Health in the US (23,38,84). The Knowledge and Ethical Value competency statements were, therefore, presented as underpinning all of the core domains on the understanding that 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.

Through the above processes, the number of competency statements was reduced from 60 to 45. The illustration of the core domains was modified to show both Knowledge and Ethical Values at the centre thus showing them as underpinning the nine other core domains (See Draft 4 in Appendix 3).

As part of the consultation process a summary of findings from both Round 2 of Delphi and from the focus groups, together with the modified Draft 4 of the framework document were sent to the CompHP Project Partners and the International Expert Advisory Group for their comments. The revised document was accepted with some minor modifications. The revised Draft 4, the product of the consensus building process from two rounds of Delphi, focus groups and feedback from Partners and the International Expert Advisory Group, was next offered for the online consultation.

**Online Consultation**

The purpose of the online consultation was to invite feedback from the wider health promotion community across Europe using an online discussion forum. A number of methods for online consultation were explored, including the use of social media tools such as Facebook and Twitter.

**Online Discussion Tools**

*Discussion fora* are hosted on websites. Members or subscribers can post comments or information to the forum and any member can post comments. The IUHPE has an established discussion forum for health promotion called Views of Health Promotion Online ([http://www.vhpo.net](http://www.vhpo.net)) and CompHP partners facilitated consultation on this site. This site provided the significant advantage of being already well established. Those who wish to
join in a discussion must register on the IUHPE website but they do not need to be an IUHPE member. Posters can retain their anonymity by using any online name they wish.

**Blog:** A blog or Weblog is a user-created website consisting of journal-style entries displayed in reverse-chronological order. Entries may contain text, links to other websites, and images or other media. Readers can respond by adding comments via a web form making it an interactive medium. For the purpose of this consultation a blog was set up using Blogspot: [http://comphpproject.blogspot.com/](http://comphpproject.blogspot.com/)

**Microblogging:** this is a hybrid of blogging, instant messaging and status notifications, allowing people to publish short messages (usually fewer than 140 characters) on the web. Twitter is one of the largest micro blogging services and a CompHP Project twitter page was set up at: [http://twitter.com/CompHPProject](http://twitter.com/CompHPProject)

**Social Networks:** These are web-based online communities, where users interact and communicate with each other and include sites such as Facebook, MySpace and Bebo. It was decided given the increased global use of Facebook to set up a CompHP Project Facebook page: [http://www.facebook.com/home.php?#!/pages/CompHP-Project/152435551461139](http://www.facebook.com/home.php?#!/pages/CompHP-Project/152435551461139)

It was decided to use a combination of all of the above media in order to reach as many interested health promotion stakeholders across Europe. A dialogue was set up on the IUHPE’s VHPO discussion forum which included a summary of the competency development process to date and also a link to Draft 4 of the Framework document on the CompHP Project website. A short Survey Monkey questionnaire was also developed and the link to this was also included. Respondents were invited to participate by completing the Survey Monkey questionnaire and by contributing to the online discussion. As a guide for discussion the questions used in the Geneva focus group sessions (see Appendix 5) were included in the opening discussion.
Various methods were used to invite the health promotion community to join the online consultations. For example, an email was sent to all on the Delphi list thanking them for their participation to date and inviting them to disseminate information on the consultation to their colleagues in health promotion. The same invitation was disseminated by Project Partners to colleagues and compatriots working in the area of health promotion. In addition, and with the help of our European partners, health promotion organisations, policy makers and academic departments were invited to participate.

Results from the Online Consultation

**VHPO Forum**

While there were few responses to the VHPO forum it was possible to determine that 536 people had viewed the discussion, indicating that it was a useful dissemination tool, if not for consultation. A total of five people responded on the forum and two indicated that they had already used the framework in their own academic settings. Other comments posted included that that the competencies were well designed and that the framework was an interesting development for the profession. One respondent remarked that while the CompHP Core Competencies Framework was aimed at health promotion professionals that the competencies listed also apply to health education as practised in the respondent’s country.

**Survey Monkey Questionnaire on VHPO Forum**

A total of 54 people responded to this questionnaire which was linked to the VHPO page. As with the previous questionnaires the responses were rated from 1-5 and means were calculated. The respondents were from the areas of academia (44.4%), practice (31.5%) and policy and others (24.1%). 48 (89.1%, mean 4.2) of those who responded felt that the framework was good or very good, 49 (90.0%, mean 4.26) felt the competencies were core and essential to health promotion practice, and 53 (98.2%, mean 4.48) responded that, while they may not use all the competencies at the one time, they considered that health
promotion practitioners should be expected to have an understanding or knowledge of the core competencies.

**Social Media**

While the social media sites were not used as tools to collect data, they were useful as additional means of dissemination of information on the Framework and on the ongoing consultation process. On the Facebook page the information posted was available to everyone, regardless of whether they were Facebook users or not. Links to all of the CompHP publications were available and the site was used to deliver reminders and updates. A total of 25 people signed up as ‘friends’ of the Project. The statistics available from Facebook indicated that the each CompHP posting received between 102-463 impressions (that is the number of people who had viewed or potentially viewed each posting). Twitter was also used to post links and reminders. At the time of the close of the online consultation Twitter had 10 followers but unfortunately more in-depth statistics were not available to assess impact.

**Other Europe Wide Consultations**

Concurrently with the online consultations, CompHP Project Partners in the Czech Republic, Estonia, Ireland and Finland organised focus groups, group discussions and consultations in their respective countries. The questions used in these consultations were the same as those used in the Geneva focus groups and for the online discussion.

**Results from Country Specific Consultations**

Feedback from the country specific consultations indicated that the primary use of the framework was likely to be in relation to quality assurance, accreditation, academia and capacity building. Some respondents considered that not all professionals working in their countries had the formal academic qualifications indicated in the framework due to current level of development of health promotion and it was noted that these practitioners may feel excluded even though they had a solid base of experience. The level of skills required by
practitioners and the settings in which health promotion is practiced were also raised, as important issues in relation to using the CompHP Core Competency Framework.

The main drivers for implementation of the Framework were identified as leadership and passion from those working in management, government ministries and a strong functioning professional governing body. The respondents also recognised their role in the successful implementation of the Framework. The lack of or limited size of professional bodies, limited interest from employers and a lack of understanding of health promotion were seen as possible barriers to the successful implementation of the Framework.

**Overall Results from Online and Country Consultations**

The overall feedback received from the VHPO discussion forum, the associated Survey Monkey questionnaire and the country specific consultations facilitated by Project Partners can be summarised as indicating that:

- The Framework was well received
- The scope and content of the Framework was deemed well balanced and appropriate for use across Europe
- The Framework is a useful tool for the health promotion profession
- The Framework gives clarity to the role of health promotion practitioners
- The Framework has a variety of uses which include course development in academia and developing job descriptions.

However, some concerns were also expressed, including:

- Some practitioners considered that repositioning of the Knowledge Domain diluted its importance and that this was a key issue as it is the specific knowledge base that makes health promotion unique
- Questions about the levels of expertise
- Potential exclusion of experienced practitioners who had no formal qualification
- The need to expand the glossary.
Final Development of the CompHP Core Competencies for Health Promotion Framework Handbook

Based on all the feedback received from this final phase of data collection the final changes to Draft 4 of the document were completed and it was prepared for publication as a Handbook.

The changes included the expansion of the Introduction to include a section on how the Handbook could be used. The Ethical Values and Knowledge Base were further defined as underpinning all health promotion action detailed in the nine other domains, each of which deal with an area of practice.

As the question of levels had arisen throughout the consultation process, despite the fact that it was clearly stated in each draft that these were entry level competencies, the section on the wider workforce was revised and a matrix to illustrate levels added as an appendix to the Handbook (See Appendix 6).

In relation to those practitioners already in practice who may not meet the required educational criteria identified in the Framework a footnote was added indicating how it could be used to formalise their experience for employment or accreditation purposes. Finally, the glossary was expanded. The CompHP Core Competencies for Health Promotion Framework Handbook was formally published on the CompHP Project website in March 201115.

CONCLUSION
The aim of Workpackage 4 was to identify, agree and publish core competencies for health promotion practice, education and training in Europe. The development of agreed core competencies in health promotion was recognised as being key to building a competent and effective health promotion workforce capable of translating into action the key priorities

identified in European health strategies and policies. The CompHP Core Competencies are, therefore, developed as a key resource for building workforce capacity to deliver public health improvement in Europe.

The CompHP Core Competencies were developed using a wide-ranging pan-European consultation process and with the input of CompHP Project Partners and an International Expert Advisory Group. The development process drew on, and has added to, the international literature on competencies and competency development in health promotion and related fields.

The consensus building processes used in developing the core competencies emphasised partnership and transparency, with each stage of the process shared with all involved. The multimethod approach used to engage stakeholders across Europe included a Delphi survey, focus groups, and also the innovative use of social media. The methods used were not only useful in developing the core competencies but have also served as a piloting process of consultation methods for the next stages of the project.

The Core Competencies for health promotion present in the Handbook are, therefore, an agreed description, within the project timeframe available, of the essential knowledge, abilities, skills and values that are needed to inform effective health promotion practice.

In developing the CompHP Project it was recognised that for some countries and regions the core competencies may be all that is useful or appropriate for their specific practice or policy context. In these instances The CompHP Core Competencies for Health Promotion Handbook may be used as a ‘standalone’ document. However, within the context of the overall Project, the core competencies are designed to form the basis for the development of Professional Standards and a pan-European Accreditation Framework for Health Promotion as additional tools for health promotion workforce capacity development across Europe.
The completed Handbook has been published on the CompHP Project website and widely disseminated to all stakeholders who contributed to the development process and key contacts across Europe.

It should be noted that, as health promotion is a dynamic and evolving field, it is recommend that that these competencies be reviewed and revised every five years.
REFERENCES


Appendix 1

CompHP Project Partners

Health Promotion Research Centre, National University of Ireland, Galway
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**Professor Alyson Taub**
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## Appendix 2

### Table 5: Map of Competencies

<table>
<thead>
<tr>
<th>Australia</th>
<th>Facilitate programme ownership and community sustainability</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand Skills</td>
<td></td>
</tr>
<tr>
<td>3.1 Contribute to the learning of others</td>
<td></td>
</tr>
<tr>
<td>3.2 Deliver and enable learning in a range of contexts</td>
<td></td>
</tr>
<tr>
<td>3.3 Develop individual skills and knowledge</td>
<td></td>
</tr>
<tr>
<td>3.4 Train the trainers/educate the educators</td>
<td></td>
</tr>
<tr>
<td>3.5 Promote workforce development and training</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Canada</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Facilitate community mobilization and build community capacity around shared health priorities that include:</td>
</tr>
<tr>
<td>5.1 Engage in a dialogue with communities based on trust and mutual respect</td>
</tr>
<tr>
<td>5.2 Identify and strengthen local community capacities to take action on health issues</td>
</tr>
<tr>
<td>5.3 Advocate for and with individuals and communities that will improve their health and wellbeing</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8.4 Identify opportunities for policy development that will improve health and wellbeing and reduce inequalities</td>
</tr>
<tr>
<td>3.9.4 Influence the development of policies and strategies to improve the population’s health and wellbeing</td>
</tr>
<tr>
<td>4.6.2 Identify opportunities and develop structures to take forward approaches to improve population health and wellbeing including making use of partnership working</td>
</tr>
<tr>
<td>4.6.7 Facilitate the development of others using a variety of methods</td>
</tr>
<tr>
<td>4.7.2 Engage and influence others in and beyond own organisation to improve population health and wellbeing</td>
</tr>
<tr>
<td>4.7.8 Build and sustain capacity and capability through individual and team development</td>
</tr>
<tr>
<td>4.8.2 Engage and lead a group to influence positively the population’s health and wellbeing</td>
</tr>
<tr>
<td>4.8.7 Build and sustain capacity and capability through individual, team, organisational and partnership development</td>
</tr>
<tr>
<td>4.9.1 Set strategic direction and vision for health and wellbeing and communicate it effectively to improve population health and wellbeing</td>
</tr>
<tr>
<td>4.9.4 Secure, prioritise and allocate resources to achieve optimal impact on population health and wellbeing</td>
</tr>
<tr>
<td>4.9.6 Lead on the sustainable development of capacity and capability to improve population health and wellbeing</td>
</tr>
<tr>
<td>5.3.3 Communicate with people about their health and wellbeing and the actions they may take to achieve improvement</td>
</tr>
</tbody>
</table>

| 5.6.1 Involve communities and the public in assessing their health and wellbeing and needs, and identifying approaches to addressing these needs |
| 5.6.2 Involve communities and the public in the planning, implementation and evaluation of health improvement programmes and projects |
2. **GCS Leadership**  
*providing strategic direction and opportunities for participation and opportunities for participation in developing healthy public policy, mobilizing and managing resources for health promotion and building capacity*

| Australia |  
|——|——|
| 3.6 | Apply interpersonal skills (negotiation, team work, motivation, conflict management, decision making, and problem solving skills); |
| 3.7 | Facilitate meetings |

| New Zealand Skills |  
|——|——|
| 6.1 | Facilitate group processes |
| 6.2 | Facilitate community processes |
| 6.3 | Acknowledge and mediate conflict |

| Canada Skills |  
|——|——|
| 6.2 | Utilize leadership, team building, negotiation and conflict resolution skills to build community partnerships |

| PHETICE |  
|——|——|
| Leadership |  

| UK |  
|——|——|
| 1.7.5 | Advise others on the collection, analysis and reporting of surveillance and assessment data for your specific area of expertise. |
| 1.8.1 | Develop and manage services and systems for describing and assessing the health and wellbeing and needs of defined populations |
| 1.9.1 | Take a strategic overview of surveillance and assessment data across a wide variety of agencies |
| 1.9.2 | Make decisions on the basis of surveillance data in a multi-agency environment |
| 2.6.6 | Advise others about using evidence in the work |
| 2.6.7 | Contribute to the development and implementation of evidence-based policies, procedures, guidelines and protocols |
| 2.7.2 | Formulate recommendations for change on the basis of critically appraised evidence |
| 3.9.2 | Lead on the development and implementation of policy and strategy to improve the population’s health and wellbeing |
| 3.9.3 | Lead on assessing the impact of policies and strategies on the population’s health and wellbeing |
| 4.6.2 | Identify opportunities and develop structures to take forward approaches to improve population health and wellbeing including making use of partnership working. |
| 4.7.1 | Manage programmes or projects to improve population health and wellbeing |
| 4.7.2 | Engage and influence others in and beyond own organisation to improve population health and wellbeing |
| 4.7.3 | Lead others across projects or programmes to improve population health and wellbeing. |
| 4.7.4 | Lead and influence change in own area of work |
| 4.7.8 | Build and sustain capacity and capability through individual and team development |
| 4.8.1 | Lead on improving population health and wellbeing within and/or across organisations |
| 4.8.4 | Manage programmes and/or services to successful completion within available resources and timescales |
| 4.8.5 | Lead change in a complex environment, handling uncertainty, the unexpected and conflicts appropriately |
| 4.9.1 | Set strategic direction and vision for health and wellbeing and communicate it effectively to improve population health and wellbeing |
| 4.9.2 | Build and sustain strategic alliances and partnerships within a politically challenging environment |
| 4.9.3 | Create and sustain infrastructure and cultures that enable strategic direction and vision to be realised |
| 4.9.4 | Secure, prioritise and allocate resources to achieve optimal impact on population health and wellbeing |
| 4.9.5 | Lead change within a politically challenging, multi-agency and multi-sectoral environment |
| 4.9.6 | Lead on the sustainable development of capacity and capability to improve population health and wellbeing |
| 4.9.7 | Maximise leadership and partnership working skills to improve population health and wellbeing, balancing the interests of organisational, political and multi-agency agendas and imperatives |
| 5.7.2 | Manage health improvement programmes across agencies, partnerships and communities |
| 5.8.3 | Advocate for communities’ health and wellbeing and their concerns |

### 3. GCS Assessment

**Scot**

- Undertake surveillance and assessment of the population-s health and well-being

- Obtain and link data and information about health and well-being and/or stressors to health and well-being

**Aust**

- Needs (or situational assessment competencies)

- Locate, conduct and critically analyse relevant literature (includes peer reviewed and grey literature, local, state and national strategic plans, and relevant area and organisational reports and policies)

- Compile an epidemiological and socio/demographic picture of the geographical or community population or setting of interest

- Involve community members and stakeholders in the needs assessment process

- Seek input from academic and practitioner specialist for the particular health issue or problem being assessed

- Determine priorities for health promotion action from available evidence using local, state and national data and information collected

- Identify behavioural, environmental, social and organisational risk and contributory factors for the particular health issue or problem of concern

- Identify processes that are effective in setting priorities for health promotion action

- Recommend specific actions based on the analysis of information.

**New Zealand Skills**

- Critically analyse and disseminate relevant research and literature

- Identify and employ a range of research approaches

**Canada**

- Conduct a community needs/situational assessment for a specific issue that includes:

  1. Conduct population assessment using health data for a specific issue

  2. Collect and critically appraise evidence(i.e. published and grey literature, systematic reviews and promising practices) on the health issue and effective interventions

  2. Conduct an environmental scan to identify community assets and resources

  2. Analyse all evidence and data to identify effective program priorities for action

**Phetice**

- Assessment and analysis

**UK**

- Surveillance and assessment of the population’s health and well-being

### Level 4

- Obtain and use routine data to describe the health and wellbeing of a defined population.

- Collect and collate basic data on health and wellbeing and the related needs of a defined population.

- Undertake simple analysis of various types of data on health and wellbeing and needs.

- Summarise and present data and the results of simple analysis of health and wellbeing and needs in simple formats.

- Check the quality of own data and results of analysis.

### Level 5

- Collect and collate routine data on health and wellbeing and needs using a range of tools and techniques.

- Analyse routine data on health and...
| 1.5.2 | wellbeing and needs using basic analytical techniques. Collect and collate non-routines data on health and wellbeing and needs that is specific to own area of expertise or practice, using specified methods and tools. Analyse non-routine data on health and wellbeing and needs that is specific to own area of expertise or practice, using basic analytical techniques. Interpret data on health and wellbeing within own area of expertise or practice. Communicate and disseminate findings of the health and wellbeing of a population to others. |
| 1.5.5 | | |
| 1.5.6 | |

**Level 6**

| 1.6.1 | |
| 1.6.2 | |
| 1.6.4 | |
| 1.6.5 | |

**Level 7**

| 1.7.1 | Assess and describe the health and wellbeing and needs of specific populations and the inequities in health and wellbeing experienced by populations, communities and groups. Measure, analyse, compare and interpret the health and wellbeing and needs of various populations, communities and groups. Identify gaps in surveillance data and initiate action to fill these gaps. Assess and describe the health and wellbeing and needs of populations using a variety of methods. |
| 1.7.2 | |
| 1.7.3 | |
| 1.7.6 | |
| 1.8.2 | |

| 2.6.1 | Frame a question to be used as the basis for reviewing literature in relation to evidence on a specific issue |
| 2.6.2 | Identify, collect and collate the evidence that is needed to answer a question on a specific issue. |
| 2.6.3 | Synthesise, appraise and summarise evidence on a specific issue |
| 2.7.1 | Critically appraise and summarise evidence from a range of sources |
| 2.7.5 | Identify gaps in evidence and initiate action to fill these gaps |
| 3.9.1 | Identify where new policies and strategies are needed to improve the population’s health and wellbeing |

**4. GCS 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*

<p>| Aus 1.2.1 | plan a comprehensive health promotion intervention to address a priority health problem in a population or setting based on an appropriate needs assessment |
| 1.2.2 | formulate appropriate, realistic and measurable programme goal and objectives |
| 1.2.3 | select appropriate (proven/best practice) mix of strategies to achieve objectives |
| 1.2.4 | identify resources (skills, personnel, partner contributions, money) available/necessary to develop, implement and evaluate a sustainable programme |
| 1.2.5 | develop a logical, sequenced and sustainable health programme based on theory and evidence with an effective action plan and a sound and adequate budget |
| 1.3.2 | critically appraise the evidence relating to interventions to identify effective and ineffective ways to address priority health issues and their contributing factors to guide programme planning and implementation |
| 1.3.4 | match strategy selection to programme objectives |
| 1.3.5 | undertake or assist in the development and implementation of a variety of health promotion strategies including health education strategies, mass media |</p>
<table>
<thead>
<tr>
<th>New Zealand</th>
<th>Knowledge 7.1</th>
<th>Knowledge of a range of planning and evaluation methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills 2.1</td>
<td>Structure planning to achieve well informed and sustainable programmes and services</td>
<td></td>
</tr>
<tr>
<td>2.3</td>
<td>Identify, use and integrate a range of health promotion strategies</td>
<td></td>
</tr>
<tr>
<td>7.3</td>
<td>Plan, conduct and write a research project.</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>3.1</td>
<td>Develop a plan to implement program goals, objectives, evaluation and implementation steps</td>
</tr>
<tr>
<td>3.2</td>
<td>Develop a budget for part of a program</td>
<td></td>
</tr>
</tbody>
</table>

Phetice (Policy and planning)

UK

1.8.3 Translate findings about health and wellbeing and needs into appropriate recommendations for action, policy decisions and service commissioning, delivery and provision

1.8.5 Contribute to the development of indicators for monitoring the population’s health and wellbeing and needs and associated targets

3.5.3 Contribute to development of specific policies and strategies.

3.7.3 Contribute to the development of policies and strategies beyond own area of work

3.7.4 Contribute to the development of policies and strategies within our own area of work

3.8.3 Develop and implement policies and strategies in own area of work

3.9.2 Lead on the development and implementation of policy and strategy to improve the population’s health and wellbeing

5.5.3 Plan, implement and review specific aspects of health improvements projects

5.6.3 Plan, implement and review health improvement programmes and projects in various settings

5.8.3 Contribute to the development of policies and strategies beyond own area of work

5.8.4 Contribute to the development of policies and strategies within our own area of work

5.8.5 Contribute to the development of policies and strategies within our own area of work

5.9.2 Lead on the development, implementation and evaluation of health improvement programmes across agencies, partnerships and communities

5. GCS 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

Australia

1.3.1 apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientation and abilities

Australia

1.3.5 undertake or assist in the development and implementation of a variety of health promotion strategies including health education strategies, mass media strategies, community development and community engagement processes, advocacy and lobbying strategies, social marketing strategies, health policy strategies, structural and environmental strategies and health impact assessment

New Zealand

Skills 1.1 Integrate the principles and provisions of Te Tiriti o Waitangi into health promotion practice

1.2 Integrate Maori perceptions and realities of health into health promotion practice
| 3.1 | Develop a plan to implement program goals, objectives, evaluation and implementation steps |
| 3.3 | Monitor and evaluate implementation of interventions |

Phetice

- **Implementation and evaluation**

UK

2.4.5 Apply evidence to own area of work

2.5.1 Collect and collate evidence from various sources identified by others

2.5.2 Assess and validate evidence from various sources

2.5.3 Synthesise and interpret evidence from various sources

2.5.5 Apply evidence in own role

2.5.6 Identify whether the benefits of own work might contribute to the development of the evidence base, and share this with others

2.5.7 Develop specific performance indicators based on evidence to review the effectiveness of own work

2.6.5 Apply evidence within own area of work

2.6.7 Contribute to the development and implementation of evidence-based policies, procedures, guidelines and protocols

2.8.1 Make and influence decisions based on evidence of effectiveness

2.8.3 Lead on the evaluation of interventions, programmes and services

2.9.5 Integrate critically appraised evidence into work programmes and services

3.5.1 Contribute to the implementation of policies and strategies in own area of work

3.5.2 Support others in implementation policies and strategies within a defined area

3.6.2 Implement relevant aspects of policies and strategies in own area of work

3.8.3 Develop and implement policies and strategies in own area of work

3.9.5 Integrate critically appraised evidence into work programmes and services

5.3.2 Implement specific activities within health improvement projects

5.4.2 Implement specific aspects of health improvement projects and approaches

5.6.3 Plan, implement and review health improvement programmes and projects in various settings

5.8.2 Lead on the development, implementation and evaluation of health improvement programmes across agencies, partnerships and communities

6. **GCS 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**

Australia

1.4.1 Incorporate evaluation into the planning of health promotion programmes

1.4.2 Identify appropriate evaluation designs

1.4.3 Design evaluation plans that incorporate process, impact, and outcome measures

1.4.4 Identify evaluation methods applicable to health promotion

1.4.5 Select evaluation instruments

1.4.6 Interpret evaluation findings

1.4.7 Monitor programmes and adjust objectives and strategies based on the analysis of evaluation data
<table>
<thead>
<tr>
<th>New Zealand Knowledge</th>
<th>Range of planning and evaluation methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canada</td>
<td>Monitor and evaluate implementation of interventions</td>
</tr>
<tr>
<td>Phetice</td>
<td>Implementation and evaluation</td>
</tr>
<tr>
<td>UK</td>
<td>Evaluate surveillance and assessment data and address any gaps and deficiencies that are found</td>
</tr>
<tr>
<td></td>
<td>Contribute to reviewing the effectiveness of own area of work</td>
</tr>
<tr>
<td></td>
<td>Review own area of work to ensure it is effective in achieving its aims</td>
</tr>
<tr>
<td></td>
<td>Lead on the evaluation of interventions, programmes and services</td>
</tr>
<tr>
<td></td>
<td>Contribute to assessing the potential or actual impact of policies and strategies on health and wellbeing in own area of work</td>
</tr>
<tr>
<td></td>
<td>Plan, implement and review specific aspects of health improvements projects</td>
</tr>
<tr>
<td></td>
<td>Plan, implement and review health improvement programmes and projects in various settings</td>
</tr>
<tr>
<td></td>
<td>Lead on the development, implementation and evaluation of health improvement programmes across agencies, partnerships and communities</td>
</tr>
<tr>
<td><strong>7. GCS</strong></td>
<td>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.</td>
</tr>
<tr>
<td>Aus</td>
<td>Undertake or assist in the development and implementation of a variety of health promotion strategies including health education strategies, mass media strategies, community development and community engagement processes, advocacy and lobbying strategies, social marketing strategies, health policy strategies, structural and environmental strategies and health impact assessment</td>
</tr>
<tr>
<td>New Zealand Skills</td>
<td>Advocate by, with and for Maori health promotion practice</td>
</tr>
<tr>
<td></td>
<td>Build inter-sectoral coalitions and strategic alliances</td>
</tr>
<tr>
<td></td>
<td>Inform, engage and support community action</td>
</tr>
<tr>
<td></td>
<td>Influence local, national and global decision/makers for health public policies</td>
</tr>
<tr>
<td></td>
<td>Pro-actively reorient health services to focus on wellbeing</td>
</tr>
<tr>
<td></td>
<td>Advocate for effective, healthy and sustainable services</td>
</tr>
<tr>
<td>Canada</td>
<td>Describe the health, economic, administrative, legal, social and political implications of policy options</td>
</tr>
<tr>
<td></td>
<td>Provide strategic policy advice on health promotion issues</td>
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</tr>
<tr>
<td>5.3</td>
<td>Advocate for and with individuals and communities that will improve their health and wellbeing</td>
</tr>
<tr>
<td>UK</td>
<td></td>
</tr>
<tr>
<td>1.7.4</td>
<td>Influence decision-making about population health and wellbeing through the presentation, communication and dissemination of data and analysis of health and wellbeing and needs</td>
</tr>
<tr>
<td>1.9.4</td>
<td>Influence policy and priority setting at national, regional or local level through the effective use of surveillance data</td>
</tr>
<tr>
<td>2.7.3</td>
<td>Influence the development of policies, procedures, guidelines or protocols on the basis of critically appraised evidence</td>
</tr>
<tr>
<td>2.8.1</td>
<td>Make and influence decisions based on evidence of effectiveness</td>
</tr>
<tr>
<td>2.8.2</td>
<td>Challenge the decisions that others make when evidence has not been taken into account</td>
</tr>
<tr>
<td>2.9.2</td>
<td>Influence political and partnership decision-making to maximise the application and use of evidence in achieving change</td>
</tr>
<tr>
<td>3.7.6</td>
<td>Provide specialist input to policies and strategies that are under development</td>
</tr>
<tr>
<td>3.8.2</td>
<td>Influence the development of policies and strategies at other levels and/or within own area of work</td>
</tr>
<tr>
<td>3.9.4</td>
<td>Influence the development of policies and strategies to improve the population’s health and wellbeing</td>
</tr>
<tr>
<td>4.5.3</td>
<td>Identify and influence other people and agencies in own area of work to improve population health and wellbeing</td>
</tr>
<tr>
<td>4.7.2</td>
<td>Engage and influence others in and beyond own organisation to improve population health and wellbeing</td>
</tr>
<tr>
<td>4.7.5</td>
<td>Advocate for health and wellbeing and reducing health inequalities</td>
</tr>
<tr>
<td>4.8.2</td>
<td>Engage and lead a group to influence positively the population’s health and wellbeing</td>
</tr>
<tr>
<td>5.6.5</td>
<td>Support communities and the public in articulating and advocating for health and wellbeing and their health concerns</td>
</tr>
<tr>
<td>5.7.3</td>
<td>Advocate for communities’ health and wellbeing and their concerns</td>
</tr>
<tr>
<td>5.9.1</td>
<td>Influence and shape the multi-agency political and policy agenda to maximise opportunities for improving population health and wellbeing and reducing inequalities</td>
</tr>
</tbody>
</table>

8. GCS Partnerships

Working collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion programmes and policies

Australia

1.3.3 | Establish and facilitate community partnerships within and outside the health sector |
2.1 | Identify partners within and outside the health sector that could determine or enhance the success of health promotion efforts |
2.2 | Develop effective partnerships with key stakeholders, gatekeepers, and target group representatives |
2.3 | Establish appropriate partnerships with relevant organisations and agencies and facilitate collaborative action |

New Zealand

Skills

2.2 | Work collaboratively when planning, implementing and evaluating programmes |
2.4 | Manage the expectations of a range of stakeholders |
4.1 | Build inter-sectoral coalitions and strategic alliances |
4.2 | Inform, engage and support community action |

Canada

6 | Engage in partnership and collaboration that includes |
6.1 | Establish and maintain linkages with community leaders and other key health promotion stakeholders (e.g. schools, businesses, faith groups, community associations, labour unions, etc.) |
6.2 | Utilize leadership, team building, negotiation and conflict resolution skills to build community partnerships |
6.3 | Build coalitions and stimulate intersectoral collaboration on health issues |
### PHETICE
#### Teamwork

**UK**

3.7.2 Work with a range of people and agencies to implement policies and strategies in interventions, programmes and services

4.3.2 Work as an effective team member

4.3.3 Work effectively with other teams to improve population health and wellbeing

4.4.1 Work effectively with people from teams and agencies other than one’s own to improve population health and wellbeing

4.4.2 Be an effective member of various teams

4.5.1 Collaborate with others effectively to improve population health and wellbeing

4.6.1 Identify opportunities and develop structures to take forward approaches to improve population health and wellbeing including making use of partnership working

4.6.6 Review the effectiveness of collaborative working and make recommendations for improvement.

4.8.3 Improve the population’s health and wellbeing through effective use of negotiating, influencing, facilitation and management skills within a multi-agency environment

4.8.6 Review collaborative working and put in place the necessary improvements.

4.8.7 Build and sustain capacity and capability through individual, team, organisational and partnership development

4.9.2 Build and sustain strategic alliances and partnerships within a politically challenging environment

4.9.7 Maximise leadership and partnership working skills to improve population health and wellbeing, balancing the interests of organisational, political and multi-agency agendas and imperatives

#### Australia

1.3.1 apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientation and abilities

#### New Zealand

1.3.1 Cultural Diversity in Aotearoa-New Zealand

2.1 Cultural awareness and responsiveness to the needs of tangata whenui

2.2 Cultural beliefs, norms and practices of different Pacific peoples

2.3 Cultural beliefs, norms and practices of Tauiwi

Sills 1.1 Integrate the principles and provisions of Te Tiriti o Waitanig into health promotion practice

1.2 Integrate Maori perceptions and realities of health into health promotion practice

#### 10. Misc

**Inequality**

3.8.4 Identify opportunities for policy development that will improve health and wellbeing and reduce inequalities

4.4.4 Promote the value of health and wellbeing and the reduction of inequalities in own work

4.6.5 Promote the value of health and wellbeing and the reduction of inequalities across settings and agencies

5.6.4 Develop resources to support health improvement and reduction of inequalities for a range of audiences

5.8.3 Build sustainable capacity and resources for health improvement and the reduction of inequalities

5.9.1 Influence and shape the multi-agency political and policy agenda to maximise opportunities for improving population health and wellbeing and reducing inequalities

5.9.3 Lead on commissioning for improving population health and wellbeing and reducing inequalities

#### 11. Misc

**Technology**

3.11 use current technology to communicate effectively

4.1 operated a computer, word processing and email systems
4.2 use software for footnotes, endnotes, and other report layout requirements
4.3 manage database and spreadsheet applications
4.4 use the internet as a work tool
4.5 use technology based systems to identify and review the literature;
4.6 operate audiovisual and multimedia equipment
Canada
7.3 Use the media, advanced technologies and community networks to receive and communicate information

12. Misc Communication
Australia 1.3.8 Develop and coordinate production of appropriated programme support materials (pamphlets, posters and other audio-visual materials)
1.4.10 communicate evaluation findings
3.1 write reports for a variety of audiences and purposes including papers for peer reviewed journals, in-house reports, programme plans and programme update reports
3.2 write for professional audiences
3.3 write for lay audiences
3.4 write submissions, grants or applications for funding
3.5 write for newspapers including media releases
3.6 apply interpersonal skills (negotiation, teamwork, motivation, conflict management, decision making, and problem-solving skills)
3.7 Facilitate meetings
3.8 debate health-related issues using evidence-based arguments
3.9 give presentations on health promotion programmes or topics at workshops or conferences
3.10 interpret information for professional, non-professional and community audiences
3.11 use current technology to communicate effectively.
New Zealand HP Skills
5.1 Communication in written form and orally to suit a range of contexts and stakeholders
5.2 Develop media skills and engage the media
5.3 Identify and develop information and resources
5.4 Demonstrate an understanding of social marketing
Canada
4.3 Write clear and concise policy statements for complex issues
7 Communicate effectively with community members and other professionals that include:
7.1 Provide health status, demographic, statistical, programmatic, and scientific information tailored to professional and lay audiences
7.2 Apply social marketing and other communication principles to the development, implementation and evaluation of health communication campaigns
7.3 Use the media, advanced technologies and community networks to receive and communicate information
7.4 Interact with and adapt policies and programming that respond to the diversity in population characteristics
PHETICE Communication
UK
1.5.6 Communicate and disseminate findings of the health and wellbeing of a population to others.
1.6.5 Present, communicate and disseminate data on health and wellbeing in a variety of ways as appropriate to various audiences
1.8.4 Disseminate the findings and implications of data relating to health and wellbeing and needs to various audiences
1.9.5 Ensure health and wellbeing surveillance data is presented in a meaningful way to all relevant audiences
2.4.3 Communicate evidence to a limited audience
2.5.4 Communicate evidence to others
2.6.4 Communicate findings of the appraisal of evidence on a specific issue
2.7.4 Advise a range of audiences about evidence
2.9.4 Communicate and disseminate critically appraised evidence to key decision-makers in various organisations
4.3.4 Communicate effectively with a range of people related to own work role
4.4.5 Communicate effectively for a range of purposes and with various audiences
4.5.6 Communicate using various techniques appropriate to the audience and the purpose of the communication
4.7.6 Work effectively with various media to communicate key issues relevant to health and wellbeing and needs
4.9.1 Advise a range of audiences about evidence
14. Misc Knowledge (hp models. Policy, determinants etc)
Australia 1.3.6 Identify theories and models that are relevant to the development and implementation of health promotion strategies outlined in the above point;
Demonstrate knowledge in
5.1 the following concepts: definition of health and health promotion, inequalities and inequities in health including the concept of the social gradient and relevance to practice, the action areas for health promotion, as well as the determinants of health (biological, behavioural and socio-environmental);
5.2 the biomedical, behavioural and socio-environmental models of health and their relevance to health promotion practice in general and needs assessment in particular
5.4 the health promotion principles of practice, evidence-based practice, equity, multidisciplinary knowledge base, intersectoral collaboration, population health approach, multi-strategic interventions, effective partnerships, cultural competence;
5.5 Stages of programme planning, strategy selection, implementation, evaluation and sustainability of programmes
5.6 relevant theories and models of behaviour change, social and political change, social marketing, organisational development
5.7 health promotion strategies to promote health – health education, advocacy, lobbying, media campaigns, community development processes, policy development, legislation
5.8 quantitative and qualitative evaluation methods and uses
5.9 descriptive statistics and basic epidemiology definitions and concepts
5.10 literature searching and critical analysis, how to access peer reviewed journals from a variety of relevant disciplines such as health promotion, public health, social sciences, public policy, communication, media and organisational change disciplines
5.11 the Australian health system and broader systems that impact on health
5.12 the use of policy in promoting and maintaining the health of populations
5.13 effective interpersonal, group and public communication and effective written and oral communication and media strategies
5.14 resource development and pre-testing resources
New Zealand 3. Origins and Evolution of Global Health Promotion,
3.1 Historical developments in health promotion philosophy and practice
<table>
<thead>
<tr>
<th>Section</th>
<th>Content, context and significance of the Ottawa Charter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current and on going developments and approaches</td>
</tr>
<tr>
<td>3.4</td>
<td>Relationship of health promotion to public health, health education and disease prevention</td>
</tr>
</tbody>
</table>

4 Theory underpinning Health Promotion Practice

<table>
<thead>
<tr>
<th>4.1</th>
<th>Models of health promotion practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2</td>
<td>Models of empowerment and enablement</td>
</tr>
<tr>
<td>4.3</td>
<td>Diverse theories of learning</td>
</tr>
<tr>
<td>4.4</td>
<td>Groups processes and dynamics</td>
</tr>
</tbody>
</table>

5 The health status of New Zealanders

<table>
<thead>
<tr>
<th>5.1</th>
<th>Wider determinants of health status and wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2</td>
<td>Lifestyle factors that influence health status and wellbeing</td>
</tr>
<tr>
<td>5.3</td>
<td>Major diseases contributing to ill health</td>
</tr>
<tr>
<td>5.4</td>
<td>Demography of health inequalities</td>
</tr>
</tbody>
</table>

6 Community and political awareness

<table>
<thead>
<tr>
<th>6.1</th>
<th>Community networks, agencies and services</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.2</td>
<td>range of information and resources available</td>
</tr>
<tr>
<td>6.3</td>
<td>Health systems and relevant structures in Aotearoa-New Zealand</td>
</tr>
<tr>
<td>6.4</td>
<td>Impact of local, national and global policies on health</td>
</tr>
<tr>
<td>6.5</td>
<td>Social movements and philosophies that influence social change</td>
</tr>
</tbody>
</table>

Canada 1. Demonstrate knowledge necessary for conducting health promotion that includes:

1.1 Apply determinants of health framework to the analysis of health issues
1.2 Apply theory to health promotion planning and implementation
1.3 Apply health promotion principles in the context of the roles and responsibilities of public health organisations
1.4 Describe the range of interventions available to address public health issues

Australia 1.3.9 co-ordinated or carry out pre-testing of programme resources,

PHETICE Information processing

UK

2.9.3 Anticipate and meet challenges to evidence in a range of political and partnership environments
Appendix 3

CompHP Core Competencies for Health Promotion Draft 1

Introduction
This document presents a set of core competencies for health promotion. These core competencies are designed to provide a minimum baseline set of competencies for entry-level health promotion practitioners in Europe. The core competencies are being developed as part of a European wide project on ‘Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe’ (CompHP) 1, which is funded by the European Agency for Health and Consumers. The CompHP project builds on a Europe-wide scoping study (1) and feasibility study (2) on implementing a competency-based accreditation system, undertaken on behalf of the IUHPE European Regional Committee. The CompHP project uses a consensus building process based on consultation with practitioners, policymakers and education providers from across the geographical spread in Europe. The project aims to develop, test and refine the implementation of a framework for competency-based standards and accreditation for health promotion in Europe.

The competency framework draws on a review of the international literature on competency development in health promotion and related fields and, in particular, on the Galway Consensus Statement (3) and the modifications suggested in a global consultation process. The core competencies for health promotion are being developed using the following processes:

- A review of the international literature, including existing competency frameworks, both published and unpublished
- Review of the draft framework by CompHP project partners and International Expert Advisory Group2
- Undertaking a Delphi survey with health promotion experts from across Europe to consider the draft framework and reach consensus on the competencies. These experts are identified from a formal stakeholder analysis using agreed criteria3
- Facilitating focus groups with members of the expert panel and other key stakeholders
- Undertaking wider consultation with practitioners, academics and policy makers in health promotion through an online consultation process
- Feedback on the development process from the CompHP partners and the International Expert Advisory Group

1 See CompHP Website at http://www.iuhpe.org/?page=614&lang=en
2 List International Expert Advisory Group
3 CRITERIA
The final framework will, therefore, be the result of an extensive consultation and consensus building process with input from international experts and health promotion specialists from across the EU member states and candidate countries.

Core Values and Principles Underpinning the CompHP Competency Framework

The competency framework is based on the core concepts and principles of health promotion as outlined in the Ottawa Charter (4) and successive WHO charters and declarations on health promotion (5-10). Health promotion is, therefore, understood to be “the process of enabling people to increase control over, and to improve, their health” (4). The Ottawa Charter embraces a positive definition of health as being, “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity”. Health is conceptualised as a resource for everyday life, emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. Health promotion represents a comprehensive social and political process which not only embraces actions directed at strengthening the skills and capabilities of individuals, but also actions directed toward changing social, environmental and economic conditions so as to alleviate their impact on public and individual health (11). Within this framework, health promotion activities are understood to be programmes, policies and other organised interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable and multi-strategy in nature (12).

This framework is underpinned by an understanding that health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (13, 14) and by the knowledge that there are well-developed theories, strategies, evidence, and values that collectively constitute a guide to good practice in health promotion (15).

Health promotion is guided by a set of core values and principles (3) 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

Core Competencies for Health Promotion Practitioners

The CompHP core competency framework is mainly aimed at health promotion practitioners whose role encompasses a major element of health promotion and who, at entry level, have a graduate or post graduate qualification in health promotion or a related discipline4. It is recognised that job titles and academic course titles may not always include

4 For example, public health, social sciences including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, political science. This is not an exclusive list as other academic qualifications may also be deemed as appropriate in given situations.
the term ‘health promotion’, given the wide range of contexts and systems within which health promotion is practiced across Europe. The terms used in this framework are designed to be relevant to all practitioners whose role reflects the Ottawa Charter (4) definition of what constitutes health promotion and which endorses the ethical principles of empowerment, equity and accountability.

A Health Promotion Practitioner is, therefore, defined for the purpose of this document as a person who works to promote the health of populations and reduce health inequities through the combined actions defined by the Ottawa Charter (4):

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services

Despite this broad definition it is recognised that the particular combination of knowledge and skills required to ensure quality health promotion practice are likely to require specific education and/or training in health promotion and ongoing professional development to maintain levels of knowledge.

Defining Core Competencies

There is no one widely agreed definition of competency despite the fact that the competency approach has been widely used in the health and other fields over the past 20 years. The definition of competency used in this framework is: ‘the ability to apply particular knowledge, skills, attitudes, and values to the standard of performance required in specified contexts’ (16). Core competencies are understood to be the minimum set of competencies that constitute a common baseline for all health promotion roles, that is ‘they are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field’ (17).

The CompHP competency framework includes all the key elements agreed to be core to health promotion practice in any setting. It is recognised that those using the competency framework may wish to identify different levels of expertise for each competency statement. Others may also wish to emphasise some competencies to a greater degree than others to meet the specific demands of their systems of workforce development, education and training, and quality assurance. It should be noted, however, that as these are core competencies, all domains should be addressed to some degree if the framework is to be used as the basis for consistent, quality practice which can be recognised internationally and, if so desired, be accredited through a pan-European accreditation system. The core competencies described here, should be subjected to a regular review process and updated in response to changes in contemporary practice.

Uses of Core Competencies for Health Promotion
It is envisaged that the Health Promotion Core Competencies can be used for a range of purposes including:

- Ensure there are clear guidelines for the knowledge, skills, attitudes and values needed to practice effectively and ethically
- Form the basis for accountable practice and quality assurance
- Assist employers and managers to gain a better understanding of health promotion roles in individual workplaces and develop appropriate job descriptions
- Assist in career planning and identify professional development and training needs
- Facilitate movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies
- Inform education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs
- Promote better communication and team work in multidisciplinary and multisectoral work settings by providing a common language and shared understanding of the key concepts and practices used in health promotion
- Contribute to greater recognition and validation of health promotion and the work done by health promotion practitioners

**CompHP Core Competency Domains and Statements**

The selection of CompHP core competencies is based on a review of the international literature, in particular on the domains of core competencies outlined in the Galway Consensus Statement (3), and the core competencies for health promotion developed in Australia (17), Canada (18), New Zealand (19) and the UK (20).

Ten domains of core competencies for entry-level health promotion practitioners are identified as follows:

1. **Enabling Change**
2. **Leadership**
3. **Assessment**
4. **Planning**
5. **Implementation**
6. **Evaluation and Research**
7. **Advocacy**
8. **Partnership**
9. **Communication**
10. **Knowledge of the theory, research, and ethical dimensions of health promotion**
1. **Enabling Change**  
*Enabling change and empowering individuals and communities to improve their health*

1.1 Enable individuals and communities to improve their health and reduce health inequities through undertaking a variety of health promotion activities including community development and empowerment strategies, advocacy and lobbying, organisational and environmental strategies, mass media strategies and health education.

1.2 Contribute to building healthy public policy across sectors and at all levels to ensure that health, economic and social policies lead to improved health and reduced health inequity.

1.3 Contribute to the creation of supportive environments to improve health and reduce health inequities utilising the settings-based approach.

1.4 Strengthen community action through promoting participatory community development processes, building capacity and capabilities within communities for improving health and engaging with communities based on trust and mutual respect.

1.5 Facilitate the development of personal skills by enabling individuals to make healthy choices and access the resources they require to improve health through health education and support for personal change.

1.6 Contribute to the reorientation of the health services towards health promotion and reducing health inequities through the provision of information, expertise, collaboration and partnership.

2. **Leadership**  
*Providing strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion, and building capacity*

2.1 Demonstrate democratic and empowerment leadership skills reflecting health promotion principles.

2.2 Contribute to the development of a vision and strategic direction for health promotion policies and programmes.

2.3 Engage and influence others in and beyond one’s own organisation to promote health and address health inequities.

2.4 Lead change in complex environments through utilising interpersonal skills (negotiation, teamwork, motivation, conflict resolution, decision making, facilitation and problem solving skills) to promote health and reduce health inequities.

2.5 Build and maintain capacity in individuals, teams, groups and communities to support the development and implementation of health promotion policies and programmes.

2.6 Mobilise and manage resources for effective and efficient health promotion programmes and policies.

2.7 Contribute to the development and implementation of evidence-based policies, procedures, guidelines and protocols for health promotion.

2.8 Synthesise new knowledge into the development of health promotion policies and practice to improve health and reduce health inequities.

2.9 Engage in reflective practice and take action to identify and meet learning and development needs at individual and organisational levels.
3. Assessment

*Conducting assessment of needs and assets in settings and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental and organisational determinants that promote or compromise health*

3.1 Collect and critically appraise relevant data, information and literature for health promotion policies and programmes from primary and secondary sources using a variety of methods

3.2 Identify and involve community members and other stakeholders in health promotion assessment processes

3.3 Identify and apply culturally relevant and appropriate health promotion assessment approaches for people from diverse cultural, socioeconomic and educational backgrounds and of all ages, genders, health status, abilities and sexual orientation

3.4 Identify existing assets and resources which can support action on health promotion

3.5 Identify the behavioural, environmental, social, cultural and organisational factors which may act as drivers and/or barriers for health promotion action

3.6 Assist populations, communities and groups to identify and articulate their experiences of health needs and capacities for health promotion action

3.7 Determine priorities for health promotion interventions based on consultation with key stakeholders, available evidence and health promotion principles

4. Planning

*Developing measurable health promotion 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*

4.1 Develop comprehensive and sequential intervention plans based on an appropriate needs assessment, current theory and available evidence of effective health promotion practice

4.2 Analyse health promotion approaches, methods and plans for their acceptability to diverse population groups

4.3 Select an appropriate mix of strategies to achieve objectives based on consultation with stakeholders and available evidence of effective health promotion interventions

4.4 Formulate and communicate appropriate, realistic and measurable goals and objectives for health promotion interventions

4.5 Identify the resources (skills, personnel, partner contributions, finance, materials, training and support) available and those required to develop, implement and evaluate sustainable health promotion interventions

4.6 Develop an action plan and adequate budget to implement effective health promotion interventions

4.7 Mobilise support and engage the participation of key stakeholders in health promotion programme development, planning and implementation

4.8 Develop evaluation plans for assessing the process, impact and outcomes of interventions based on health promotion principles and consultation with key stakeholders

4.9 Develop effective feedback mechanisms within process evaluation to ensure that health promotion interventions are being implemented as intended and that contingency plans for programme improvement are in place
5. Implementation

Carrying out effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources

5.1 Apply culturally relevant and appropriate health promotion approaches for people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, abilities and sexual orientation

5.2 Develop and pilot health promotion programme resources and materials

5.3 Implement health promotion strategies using ethical, empowering and participatory processes appropriate to the context of specific settings

5.4 Monitor the quality and quantity of health promotion programme implementation.

5.5 Use feedback from process evaluation to maintain and improve the effective implementation of planned health promotion interventions

5.6 Manage resources, including the necessary staffing, skills and budgets needed for the effective implementation of health promotion interventions

5.7 Facilitate programme ownership and sustainability of effective health promotion interventions through ongoing consultation and collaboration with key stakeholders

6. Evaluation and Research

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

6.1 Incorporate evaluation into the planning and implementation of all health promotion activities

6.2 Engage with research experts on the development and application of research methods for monitoring and evaluation based on appropriate research designs, health promotion principles and ethics

6.3 Apply health promotion evaluation and monitoring methods to incorporate process, impact, and outcome measurement, facilitating the participation of stakeholders

6.4 Apply evaluation findings to refine and improve health promotion interventions and support the sustainability and dissemination of effective practice

6.5 Communicate evaluation findings to stakeholders using language appropriate for diverse audiences

6.6 Critically appraise the practice and policy implications of quantitative and qualitative data derived from the monitoring and evaluation of health promotion activities

6.7 Contribute to the advancement of health promotion knowledge and practice through the use of research and evidence-based strategies

6.8 Plan, conduct and write up health promotion evaluation initiatives and prepare research proposals for funding

6.9 Critically analyse and disseminate relevant health promotion research and literature

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
7.1 Identify and create opportunities to advocate for and with individuals, groups, communities and organisations on promoting their health and addressing health inequities

7.2 Identify strategic alliances and mechanisms for advancing health promotion policy and practice

7.3 Identify and critique opposing arguments relating to health promotion and develop strategies to address them

7.4 Develop, implement and evaluate advocacy plans for health promotion using a range of advocacy strategies and techniques

7.5 Raise awareness and influence public opinion on health promotion by identifying and accessing relevant media and disseminating a range of resources and information

7.6 Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non governmental organisations) on the development and implementation of health promotion policies and programmes

7.7 Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers

7.8 Ensure processes are in place to enable and support communities in the articulation of their views and concerns about health promotion and health inequities

7.9 Contribute to influencing and shaping organisational, multiagency, regional and national agencies to maximise opportunities for health promotion and reduce health inequities

7.10 Provide health promotion input into policies and strategies which impact on health and health inequities

7.11 Advocate for the development of policies, guidelines and procedures which impact favourably on health and reduce health inequities

8. Partnership

Working collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion programmes and policies

8.1 Identify partners within and outside the health sector with the potential to support the development and implementation of health promotion policies and programmes

8.2 Facilitate intersectoral collaboration and build partnerships for health promotion using leadership, team building, negotiation and conflict resolution skills

8.3 Establish and maintain effective partnership working with key health promotion stakeholders, including, statutory bodies, community groups and voluntary/non-governmental organisations

8.4 Develop and sustain local, regional and national coalitions and networks for advancing intersectoral health promotion policies and programmes

8.5 Mediate between different sectoral interests and manage the collaborative process in the development and implementation of health promotion policies and programmes

8.6 Review the effectiveness of partnerships and collaborative working for health promotion and make recommendations for improvements
9. Communication

Communicating health promotion activities and programmes effectively using appropriate methods for diverse audiences

9.1 Communicate and disseminate data and information on health promotion policies and programmes to a range of diverse audiences

9.2 Use the media, advanced technologies and relevant networks to receive and communicate information on health promotion

9.3 Develop and disseminate written, oral and electronic communication (including reports, presentations and targeted messages) on health promotion policies and programmes tailored to diverse contexts and settings

9.4 Use effective and culturally appropriate health promotion communication methods, techniques and language suitable for specific population groups

9.5 Apply interpersonal communication and groupwork skills to facilitate individuals, groups and communities to increase control over their health and reduce health inequities

9.6 Apply a range of communication skills to facilitate the development of personal skills and community action for health promotion

9.7 Promote and debate the merits of health promotion strategies using evidence-based arguments

10. Knowledge Competencies

Demonstrate an understanding of, and the ability to apply in practice, the theory, research and ethical dimensions of health promotion and the multidisciplinary knowledge base which underpins the competencies listed above

10.1 Appreciation of the history and development of health promotion, including the Ottawa Charter (WHO, 1986) and successive charters and declarations, which provide the foundations for health promotion practice

10.2 Understanding of the core concepts and principles of health promotion and their application in practice

10.3 Understanding of the theories, research and multidisciplinary knowledge base underpinning health promotion and their application in the development and implementation of health promotion practice, policy and research

10.4 Awareness and understanding of the ethical dimensions of health promotion and their application in practice

10.5 Appreciation of the importance of context for health promotion practice and the socio-ecological model of the settings-based approach

10.6 Knowledge of the biological, behavioural and socio-environmental determinants of health and their implications for the development of effective health promotion policies and programmes

10.7 Understanding of the concepts of health inequalities and inequities, their impact on health status and their relevance for health promotion policies and programmes

10.8 Appreciation of the impact of local, national, regional and international health systems, policies and priorities on health promotion practice

10.9 Awareness of, and sensitivity to, social and cultural diversity in all aspects of health promotion practice
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CompHP Core Competencies for Health Promotion Draft 2

Introduction
This document presents a set of core competencies for health promotion practitioners in Europe. The core competencies are being developed as part of a European wide project on ‘Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe’ (CompHP) ⁵, which is funded by the European Agency for Health and Consumers. The CompHP project builds on a Europe-wide scoping study (1) and a feasibility study (2) on implementing a competency-based accreditation system, undertaken on behalf of the IUHPE European Regional Committee. The project aims to develop, test and refine the implementation of a framework for competency-based standards and accreditation for health promotion in Europe. The project uses a consensus building process based on consultation with practitioners, policymakers and education providers across Europe.

The competency framework draws on a review of the international literature on competency development in health promotion and related fields and, in particular, on the Galway Consensus Statement (3) and the modifications suggested in a global consultation process.

The core competencies for health promotion are being developed using the following processes:

- Review of the international literature, including existing competency frameworks, both published and unpublished
- Review of the draft framework by CompHP project partners and International Expert Advisory Group ⁶
- Undertaking a Delphi survey with health promotion experts from across Europe to consider the draft framework and reach consensus on the competencies. Experts are identified from a formal stakeholder analysis using agreed criteria ⁷
- Facilitating focus groups with members of the expert panel and other key stakeholders
- Undertaking wider consultation with practitioners, academics and policy makers in health promotion through an online consultation process
- Feedback on the development process from the CompHP partners and the International Expert Advisory Group

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⁵ See CompHP Website at http://www.iuhpe.org/?page=614&lang=en
⁶ List International Expert Advisory Group Available on CompHP website
⁷ The criteria for inclusion in the sample are 6 representatives from each country, 2 practice, 2 policy and 2 academic based on, in order of priority: National role in health promotion, experience in health promotion, experience in competency approach
The final framework will, therefore, be the result of an extensive consultation and consensus building process with input from international experts and health promotion specialists from across Europe.

**Core Values and Principles Underpinning the CompHP Competency Framework**

The competencies are based on the core concepts and principles of health promotion as outlined in the Ottawa Charter (4) and successive WHO charters and declarations on health promotion (5-10). Health promotion is, therefore, understood to be ‘the process of enabling people to increase control over, and to improve, their health’ (4). The Ottawa Charter embraces a positive definition of health as being, ‘a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity’. Health is conceptualised as a resource for everyday life, emphasising social and personal resources, as well as physical capacities. Therefore, health promotion is viewed as not only the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. Health promotion therefore is a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also action directed toward changing social, environmental and economic conditions so as to alleviate their impact on public and individual health (11). Within this set of competencies, health promotion activities are understood to be programmes, policies and other organised interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable and multi-strategy in nature (12).

The competencies are underpinned by an understanding that health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (13, 14) and by the knowledge that there are well-developed theories, strategies, evidence, and values that collectively constitute a guide to good practice in health promotion (15). Health promotion is guided by a set of core values and principles (3) 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

**Core Competencies for Health Promotion Practitioners**

The CompHP core competencies are mainly aimed at health promotion practitioners whose prime role and function is health promotion and who have a graduate or post graduate qualification in health promotion or a related discipline8. It is envisioned that the core competencies could, in the future, form the basis for developing more advanced competencies for practitioners working in more senior management positions in health promotion and could also be adapted to identify more specialised competencies for health

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8 For example, public health, social sciences including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, political science. This is not an exclusive list as other academic qualifications may also be deemed as appropriate in given situations.
promoters working in more specialised roles. It is recognised that job titles and academic course titles may not always include the term ‘health promotion’, given the wide range of contexts and systems within which health promotion is practiced across Europe. However, this framework is designed to be relevant to all practitioners whose main role reflects the Ottawa Charter (4) definition of what constitutes health promotion and which endorses the ethical principles of empowerment, equity and accountability.

A health promotion practitioner is, therefore, for the purpose of this document, defined as a person who works to promote the health and reduce health inequities through the combined actions defined by the Ottawa Charter (4):

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services

Despite this broad definition it is recognised that the particular combination of knowledge and skills required to ensure quality health promotion practice need specific education and/or training in health promotion and ongoing professional development to maintain levels of knowledge.

**Defining Core Competencies**

There is no one widely agreed definition of competencies despite the fact that the competency approach has been widely used in the health and other fields for over 20 years. The definition of competencies used in this framework is: ‘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’ (16). Core competencies are understood to be the minimum set of competencies that constitute a common baseline for all health promotion roles, that is ‘they are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field’ (17).

**Uses of Core Competencies for Health Promotion**

It is envisaged that the Health Promotion Core Competencies can be used for a range of purposes including:

- Ensuring that there are clear guidelines for the knowledge, skills, attitudes and values needed to practice effectively and ethically
- Forming the basis for accountable practice and quality assurance
- Assisting employers and managers to gain a better understanding of health promotion roles in individual workplaces and develop appropriate job descriptions
- Assisting in career planning and identifying professional development and training needs
- Facilitating movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies
- Informing education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs
• Promoting better communication and team work in multidisciplinary and multisectoral settings by providing a common language and shared understanding of the key concepts and practices used in health promotion
• Contributing to greater recognition and validation of health promotion and the work done by health promotion practitioners

The CompHP competencies include all the key elements agreed to be core to health promotion practice in any setting. It is recognised that those using the competencies may wish to identify different levels of expertise for each of the competencies statements. Others may also wish to emphasise some competencies to a greater degree than others to meet the specific demands of their systems in relation to workforce development, education and training and quality assurance. It should be noted, however, that as these are core competencies, all domains should be addressed to some degree if they are to be used as the basis for consistent, quality practice which can be recognised internationally and, if so desired, be accredited through a pan-European accreditation system.
The core competencies described here, should be subjected to a regular review process and updated in response to changes in contemporary practice.

CompHP Core Competency Domains and Statements
The selection of the CompHP core competencies is based on a review of the international literature, in particular on the domains of core competencies outlined in the Galway Consensus Statement (3) and the core competencies for health promotion developed in Australia (17), Canada (18), New Zealand (19) and the UK (20).

Ten domains of core competencies for health promotion practitioners are identified as follows:

1. Enabling Change
2. Leadership
3. Assessment
4. Planning
5. Implementation
6. Evaluation and Research
7. Advocacy
8. Partnership
9. Communication
10. Knowledge
1. Enabling Change

Enabling change and empowering individuals and communities to improve their health

1.1 Enable individuals and communities to improve their health and reduce health inequities through undertaking a variety of health promotion activities including community development and empowerment strategies, advocacy and lobbying, organisational and environmental strategies, mass media strategies and health education

1.2 Contribute to building healthy public policy across all sectors and levels to ensure that health, economic and social policies lead to improved health and reduced health inequities

1.3 Contribute to the creation of supportive environments to improve health and reduce health inequities using approaches such as the settings-based approach

1.4 Strengthen community action by facilitating community participation and ownership through community development processes, and building capacity within communities for improving health based on mutual trust and respect

1.5 Facilitate the development of personal skills by enabling individuals to make healthy choices and access the resources they require to improve health through health education and strategies that support personal change

1.6 Contribute to the reorientation of the health services towards health promotion and reducing health inequities through the provision of information, expertise, collaboration and partnership

2. Leadership

Contribute to the provision of strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion, supporting health promotion programmes and building capacity

2.1 Demonstrate democratic and empowerment leadership skills reflecting health promotion principles

2.2 Contribute to the development of a vision and strategic direction for health promotion policies and programmes

2.3 Work to influence one’s own and other organisations and key stakeholders to promote health and address health inequities

2.4 Demonstrate leadership in facilitating change through utilising interpersonal skills (negotiation, teamwork, motivation, conflict resolution, decision making, facilitation and problem solving skills) to promote health and reduce health inequities

2.5 Build and maintain capacity in individuals, teams, groups and communities to support the development and implementation of sustainable health promotion policies and programmes

2.6 Mobilise and manage resources for effective and efficient health promotion programmes and policies

2.7 Contribute to the development and implementation of ethical and evidence-based policies, procedures, guidelines and protocols for health promotion

2.8 Synthesise new knowledge and processes into the development of health promotion policies and practice to improve health and reduce health inequities
2.9 Engage in reflective practice and take action to identify and meet learning and development needs at individual and organisational levels

3. Assessment

*Conducting assessment of needs and assets in settings and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental, organisational and political determinants that promote or compromise health*

3.1 Collect, review and critically appraise relevant data, information and literature for health promotion policies and programmes from primary and secondary sources using a variety of methods including social sciences and epidemiological methods
3.2 Identify and involve community members and other stakeholders in health promotion assessment processes
3.3 Identify, adapt and apply culturally relevant and appropriate health promotion assessment approaches for people from diverse cultural, socioeconomic and educational backgrounds and of all ages, genders, health status, abilities and sexual orientation
3.4 Identify existing assets and resources at all levels in organisations and communities which can support action on health promotion to improve health and reduce health inequities
3.5 Identify the environmental, social, cultural, organisational, behavioural and biological factors which may act as barriers to, or drivers for health promotion action
3.6 Assist populations, communities and groups to articulate their experiences of health needs and to identify capacities for health promotion action
3.7 Identify priorities for health promotion interventions based on consultation and in partnership with key stakeholders, available evidence and health promotion principles

4. Planning

*Developing measurable health promotion 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*

4.1 Develop comprehensive and sequential intervention plans based on an appropriate assessment of needs and assets, theory and available evidence of effective health promotion practice
4.2 Review health promotion approaches, methods and plans for their acceptability to diverse population groups
4.3 Identify an appropriate mix of strategies to achieve objectives based on consultation with stakeholders and available evidence of effective health promotion interventions
4.4 Formulate and communicate appropriate, realistic and measurable goals and objectives for health promotion interventions
4.5 Identify the resources (skills, personnel, partner contributions, finance, materials, training and support) available and those required to develop, implement and evaluate sustainable health promotion interventions
4.6 Develop a feasible action plan and an adequate budget to implement effective health promotion interventions
4.7 Mobilise support and engage the participation of key stakeholders in health promotion programme and policy development, planning and implementation
4.8 Develop evaluation plans to assess the process, impact and outcomes of interventions based on health promotion principles and in consultation with key stakeholders.

4.9 Develop effective feedback mechanisms as part of process evaluation to ensure that health promotion interventions are being implemented as intended and that contingency plans for programme improvement are in place.

5. Implementation

Carrying out effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources.

1.1 Use culturally relevant and appropriate health promotion approaches for diverse cultural, socioeconomic and educational groups, and persons of all ages, genders, sexual orientation, ethnicity, health status and abilities.

1.2 Develop, pilot and use appropriate health promotion programme resources and materials in collaboration with stakeholder groups.

1.3 Implement health promotion strategies using ethical, empowering and participatory processes appropriate to specific contexts.

1.4 Ensure that the quality of implementation of health promotion programmes is monitored and meets agreed goals and objectives.

1.5 Use feedback from process evaluation to maintain and improve the effective implementation of planned health promotion interventions.

1.6 Manage resources, including the necessary staffing, skills and budgets needed for the effective implementation of health promotion interventions.

1.7 Facilitate programme ownership and sustainability of effective health promotion interventions through ongoing consultation and collaboration with key stakeholders.

6. Evaluation and Research

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.

6.1 Incorporate evaluation into the planning and implementation of all health promotion activities.

6.2 Identify the need for, and engage with technical and research expertise as required to develop and apply research methods for monitoring and evaluation.

6.3 Use appropriate health promotion evaluation and monitoring methods incorporating process, impact and outcome measurement, in partnership with stakeholders.

6.4 Apply evaluation findings to refine and improve health promotion interventions and support the sustainability and dissemination of effective practice.

6.5 Communicate clearly evaluation findings to diverse stakeholder groups.

6.6 Critically consider the practice and policy implications of findings from the monitoring and evaluation of health promotion activities.

6.7 Contribute to the advancement of health promotion knowledge and practice through the use of research and evidence-based strategies.

6.8 Contribute to planning, conducting and writing health promotion evaluation initiatives and preparing research proposals for funding.

6.9 Review and disseminate relevant health promotion research and literature.
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

7.1 Identify and create opportunities to advocate for and with individuals, groups, communities and organisations to improve their health and address health inequities
7.2 Identify strategic alliances and mechanisms for advancing health promotion policy and practice
7.3 Identify critiques of health promotion and develop strategies to respond to them
7.4 Develop, implement and evaluate advocacy plans for health promotion using a range of advocacy strategies and techniques
7.5 Raise awareness and influence public opinion on health promotion by identifying and accessing relevant media and disseminating a range of resources and information
7.6 Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non-governmental organisations) on the development and implementation of health promotion policies and programmes
7.7 Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers
7.8 Enable and support communities in the articulation of their views and concerns about health and health inequities
7.9 Contribute to influencing and shaping organisational, multiagency, regional and national agencies to maximise opportunities for health promotion and reduce health inequities
7.10 Advocate for the development of policies, guidelines and procedures which impact favourably on health and reduce health inequities and provide health promotion input into their development

8. Partnership
Work collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion programmes and policies

8.1 Identify partners within and outside the health sector with the potential to support the development and implementation of health promotion policies and programmes
8.2 Facilitate intersectoral collaboration and build partnerships for health promotion using leadership, team building, negotiation and conflict resolution skills
8.3 Establish and maintain effective partnership working with key health promotion stakeholders, including, statutory bodies, community groups and voluntary/non-governmental organisations
8.4 Develop and sustain local, regional and national coalitions and networks for advancing intersectoral health promotion policies and programmes
8.5 Mediate between different sectoral interests and manage the partnership process in the development and implementation of health promotion policies and programmes
8.6 Review the effectiveness of partnerships and collaborative working for health promotion and make recommendations for improvements
9. Communication

*Communicating health promotion activities and programmes effectively using appropriate methods for diverse audiences*

9.1 Communicate and disseminate data and information on health promotion policies and programmes to a range of diverse audiences

9.2 Use the media, advanced technologies and relevant networks to receive and communicate information on health promotion

9.3 Develop and disseminate written, oral and electronic communication (including reports, presentations and focused messages) on health promotion policies and programmes tailored to specific contexts

9.4 Use effective and culturally appropriate health promotion communication methods, techniques and language suitable for specific population groups

9.5 Apply interpersonal communication and groupwork skills to facilitate individuals, groups and communities to increase control over their health and reduce health inequities

9.6 Apply a range of communication skills to facilitate the development of personal skills and community action to improve health and reduce health inequities

9.7 Promote and debate the merits of diverse health promotion strategies using ethical, theoretical and evidence-based arguments

10. Knowledge

*Demonstrate understanding of, and the ability to apply in practice, the theory, research and ethical dimensions of health promotion and the multidisciplinary knowledge base which underpins the competencies listed above*

10.1 Demonstrate knowledge of the history and development of health promotion internationally including the Ottawa Charter (WHO, 1986) and successive charters and declarations as the foundations for health promotion practice

10.2 Demonstrate understanding of the core concepts and principles of health promotion and their application in practice

10.3 Demonstrate understanding of the concepts of health inequalities and inequities, their impact on health status and their relevance for health promotion policies and programmes

10.4 Demonstrate understanding of the theories, research and multidisciplinary knowledge base underpinning health promotion and their application in the development and implementation of health promotion practice, policy and research

10.5 Demonstrate knowledge and understanding of the ethical dimensions of health promotion and their application in practice

10.6 Demonstrate understanding of the importance of context for practice based on the socio-ecological model of health promotion

10.7 Demonstrate knowledge of the social, environmental, behavioural and biological determinants of health and their implications for the development of effective health promotion policies and programmes

10.8 Demonstrate awareness and knowledge of the impact of local, national, regional and international health systems, policies and priorities and their impact on health promotion practice

10.9 Demonstrate knowledge of, and sensitivity to, social and cultural diversity in all aspects of health promotion practice
Glossary

In addition to the terms defined in this glossary, the project uses the definitions from the World Health Organisation’s (WHO) Glossary of Health Promotion (http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf) and in the update (http://heapro.oxfordjournals.org/cgi/reprint/dal033v1.pdf) The wording in some of the definitions has been slightly changed from the original reference to make them more directly relevant to the CompHP Project

Capacity Building: an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. (21)

Competencies: 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. (16)

Competencies as described in health promotion literature:

- Refer not only to the knowledge, but also to the skills and attitudes needed to produce a performance
- Focus on doing and acting so that a competent person not only knows something, but also knows how to do something with what they know
- Have to do with the capacity to face new contexts and respond to new challenges. (22)

Consensus: means overwhelming agreement. It is important that consensus be the product of a good-faith effort to meet the interests of all stakeholders. The key indicator of whether or not a consensus has been reached is that everyone agrees they can live with the final proposal after every effort has been made to meet any outstanding interests. Most consensus building efforts set out to achieve unanimity, however, it often becomes clear that there are people who believe that their interests will be better served by remaining outside the emerging agreement. Most consensus processes seek unanimity, but settle for overwhelming agreement that goes as far as possible toward meeting the interests of all stakeholders. It is absolutely crucial that this definition of success be clear at the outset of the process. (23)

Consultation: a tool for managing two-way communications between project developers and stakeholders. The goal is to improve decision-making, reduce risk, and build understanding by actively involving individuals, groups, and organisations with a stake in the project. Their involvement increases the project’s long-term viability and enhances its benefits to stakeholders. To be meaningful, consultation should be carried out in a culturally appropriate manner, with locally appropriate timeframes and in local languages. (24)

Continuing professional development (CPD): refers to study designed to upgrade knowledge and skills of practitioners in the professions. (25)

Core competencies: are the minimum sets 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. (17)

**Delphi Method/technique:** is an iterative process used to collect and distil the judgments of experts using a series of questionnaires interspersed with feedback. Each subsequent questionnaire is developed based on the results of the previous questionnaire. The process stops when the research question is answered: for example, when consensus is reached, theoretical saturation is achieved, or when sufficient information has been exchanged. The Delphi method has its origins in the American business community, and has since been widely accepted throughout the world in many sectors including health care, defence, business, education, information technology and engineering. (26)

**Experts:** people who have an above average knowledge in a specific field of significance. They usually have experience, training, education, and/or an enthusiasm for the field of significance. (27)

**Inequity/Inequality:** The concept of *inequity* has been considered synonymous with the concept of *inequality*; however, while inequality implies differences between individuals or population groups, inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. Not all inequalities are unjust, but all inequities are the product of unjust inequalities. The definitions of *just* and *unjust* are subject to various interpretations. In the context of health, one of the more accepted definitions of "just" refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay. (28)

**Partner:** the individual and/or organisation with which one collaborates to achieve mutually agreed upon objectives. (24)

**Partnership:** a collaborative relationship of individuals and/or organisations within which partners set aside personal or organisational agendas to achieve the agenda of the partnership. In a partnership, the partners engage as equals in the decision-making process. In effective partnerships, partners share a vision, are committed to the integrity of the partnership, agree on specific goals, and develop a plan of action to accomplish the goals. (29)

**Stakeholder:** those groups or individuals: (a) that can reasonably be expected to be significantly affected by the project’s activities, products, and/or services; or (b) whose actions can reasonably be expected to affect the ability of the project to successfully implement its strategies and achieve its objectives. They can be an individual, community or organisation that affects, or is affected by, the operations of the project. Stakeholders may be individuals, interest groups, government agencies, or corporate organisations. (24)
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Introduction
This document presents a set of core competencies for health promotion practitioners in Europe. The core competencies are being developed as part of a European wide project on ‘Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe’ (CompHP)\(^9\), which is funded by the European Agency for Health and Consumers. The CompHP project builds on a Europe-wide scoping study (1) and a feasibility study (2) on implementing a competency-based accreditation system, undertaken on behalf of the IUHPE European Regional Committee. The project aims to develop, test and refine the implementation of a framework for competency-based standards and accreditation for health promotion in Europe. The project uses a consensus building process based on consultation with practitioners, policymakers and education providers across Europe. This document concerns specifically the development of the competency framework as part of the overall CompHP project.

The competency framework is informed by a review of competency developments in health promotion and related fields in Europe and internationally. The core competencies for health promotion are being developed using the following processes:

- Review of the international and European literature, including existing competency frameworks, both published and unpublished (Dempsey, Barry and Battell-Kirk, 2010)
- Review of the draft framework by CompHP project partners and International Expert Advisory Group\(^10\)
- Delphi survey with health promotion experts from across Europe to consider the draft framework and reach consensus on the competencies. Experts are identified from a formal stakeholder analysis using agreed criteria\(^11\)
- Focus groups with health promotion experts and other key stakeholders from across Europe
- Consultation with practitioners, academics and policy makers in health promotion through an online consultation process
- Feedback on the development process from the CompHP partners and the International Expert Advisory Group

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\(^10\) List International Expert Advisory Group Available on CompHP website
\(^11\) The criteria for inclusion in the sample are 6 representatives from each country, 2 each from the areas of practice, policy and academia based on, in order of priority: national role in health promotion, experience in health promotion, experience in the competency approach.
The final framework will, therefore, be the result of an extensive consultation and consensus building process with input from international experts and health promotion specialists from across Europe.

**Core Values and Principles Underpinning the CompHP Competency Framework**

The competencies are based on the core concepts and principles of health promotion as outlined in the Ottawa Charter (4) and successive WHO charters and declarations on health promotion (5-10). Health promotion is, therefore, understood to be ‘the process of enabling people to increase control over, and to improve, their health’ (4). The Ottawa Charter embraces a positive definition of health as being, ‘a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity’. Health is conceptualised as a resource for everyday life, emphasising social and personal resources, as well as physical capacities. Health promotion is viewed as not only the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. Health promotion, therefore, is a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also action directed toward changing social, environmental and economic conditions so as to alleviate their impact on public and individual health (11). Within this set of competencies, health promotion actions are understood to be programmes, policies and other organised interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable and multi-strategy in nature (12).

The competencies are underpinned by an understanding that health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (13, 14) and by the knowledge that there are well-developed theories, strategies, evidence and values that collectively constitute a guide to good practice in health promotion (15).

Health promotion is guided by a set of core values and principles (3) 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, planning, implementing and evaluating the practical and feasible health promotion solutions to address needs

**Core Competencies for Health Promotion Practitioners**

The CompHP core competencies are mainly for use by health promotion practitioners whose prime role and function is health promotion and who have a graduate or postgraduate qualification in health promotion or a related discipline12. The framework may also be useful to those working in other professional areas, e.g. community health, whose role may include health promotion. It is envisioned that the core competencies, could in the

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12 For example, public health, social sciences including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, political science. This is not an exclusive list as other academic qualifications may also be deemed as appropriate in given situations.
future, form the basis for developing more advanced competencies for practitioners working in more senior management positions in health promotion and could also be adapted to identify more specialised competencies for health promoters working in more specialised roles. It is recognised that job titles and academic course titles may not always include the term ‘health promotion’, given the wide range of contexts and systems within which health promotion is practiced across Europe. However, this framework is designed to be relevant to all practitioners whose main role reflects the Ottawa Charter (4) definition of what constitutes health promotion and which endorses the ethical principles of empowerment, equity and accountability.

A health promotion practitioner for the purpose of this document, is defined as a person who works to promote health and reduce health inequities through the actions defined by the Ottawa Charter (4):

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services

Despite this broad definition it is recognised that the particular combination of knowledge and skills required to ensure quality health promotion practice need specific education and/or training in health promotion and ongoing professional development to maintain levels of knowledge.

**Defining Core Competencies**

There is no agreed definition of competencies despite the fact that the competency approach has been widely used in the health and other fields for over 20 years. The definition of competencies used in this framework is: ‘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’ (16). Core competencies are understood to be the minimum set of competencies that constitute a common baseline for all health promotion roles, that is ‘they are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field’ (17).

**Uses of Core Competencies for Health Promotion**

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

- Ensuring that there are clear guidelines for the knowledge, skills, attitudes and values needed to practice effectively and ethically
- Forming the basis for accountable practice and quality assurance
- Assisting employers and managers to gain a better understanding of health promotion roles in individual workplaces and develop appropriate job descriptions
- Assisting in career planning and identifying professional development and training needs
- Facilitating movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies
• Informing education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs
• Promoting better communication and team work in multidisciplinary and multisectoral settings by providing a common language and shared understanding of the key concepts and practices used in health promotion
• Contributing to greater recognition and validation of health promotion and the work done by health promotion practitioners

The CompHP competencies include all the key elements agreed to be core to health promotion practice in any setting. It is recognised that those using the competencies may wish to identify different levels of expertise for each of the competencies statements or emphasise some competencies to a greater degree than others. However, as these are core competencies, all domains should be addressed to some degree if they are to be used as the basis for consistent, quality practice which can be recognised internationally and, if so desired, be accredited through a pan-European accreditation system. The core competencies described here, should be subjected to a regular review process and updated in response to changes in contemporary practice.

**CompHP Core Competency Domains and Statements**

The selection of the CompHP core competencies is based on a review of the international and European literature, in particular the domains of core competencies outlined in the Galway Consensus Statement (3), together with the modifications to the statement suggested in a global consultation process, and the core competencies for health promotion developed in Australia (17), Canada (18), New Zealand (19) and the UK (20).

For the purposes of this document the term ‘health promotion actions’ is used throughout to indicate programmes, policies and other organised health promotion interventions.

The ten domains of core competencies for health promotion practitioners, as illustrated in Figure 1, are:

1. **Knowledge**
2. **Enable Change**
3. **Advocacy**
4. **Mediate through Partnership**
5. **Communication**
6. **Leadership**
7. **Needs Assessment**
8. **Planning**
9. **Implementation**
10. **Evaluation and Research**
Figure 1: Illustration of CompHP Competency Domains
1. **Knowledge**

*Demonstrate understanding of, and the ability to apply in practice, the theory, research, values and multidisciplinary knowledge base of health promotion which underpins the competencies including:*

1.1 The history and development of health promotion internationally, including the Ottawa Charter (WHO, 1986) and successive charters and declarations
1.2 The core concepts and principles of health promotion and their application in practice
1.3 The concepts of equity and social justice, their impact on health status and relevance for health promotion
1.4 The theories and research underpinning health promotion and their application in practice
1.5 The socio-ecological model of health (social, environmental, behavioural and biological determinants) as the basis for health promotion and its implications for practice
1.6 The impact of local, national, regional and international health systems, policies and priorities and their relevance for health promotion actions
1.7 The implications of social and cultural diversity in all aspects of health promotion

2. **Enable Change**

*Enable individuals, communities and organisations to improve health and reduce health inequities through undertaking a variety of health promotion actions:*

2.1 Work across sectors to ensure that all health, economic and social policies lead to improved health and reduced health inequities
2.2 Use a range of approaches such as the settings-based approach to create environments which support health
2.3 Facilitate community participation and ownership in health promotion actions through community development processes and building capacity within communities
2.4 Facilitate the development of personal skills to maintain and improve health using empowerment strategies
2.5 Work in collaboration with key stakeholders to reorient health services towards health promotion

3. **Advocacy**

*Advocate with, and on behalf, of individuals, communities and organisations to improve health and well-being and build capacity for undertaking health promotion actions:*

3.1 Use a range of advocacy strategies and techniques which reflect health promotion principles
3.2 Identify and create opportunities for advocacy on health promotion actions
3.3 Facilitate communities and groups to articulate their experiences of health needs and to identify capacities for health promotion action
3.4 Raise awareness and influence public opinion on health issues by identifying and accessing relevant media and disseminating a range of resources and information
3.5 Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non-governmental organisations) to advocate for health promotion action
3.6 Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers
3.7 Advocate for the development of policies, guidelines and procedures which impact positively on health and reduce health inequities

4. Mediate through Partnership
Mediate and work collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion actions:

4.1 Identify and engage partners from different sectors who have the potential to actively contribute to the development and implementation of health promotion actions
4.2 Facilitate intersectoral collaboration by mediating between different sectoral interests
4.3 Establish and manage effective partnership working with key stakeholders, including statutory bodies, community groups and voluntary/non-governmental organisations
4.4 Sustain local, regional and national coalitions and networks for health promotion action
4.5 Monitor and review partnership working in terms of impact, outcome and adherence to health promotion principles

5. Communication
Communicate health promotion actions effectively using appropriate methods for diverse audiences:

5.1 Use a range of skills including written, verbal, non-verbal and listening skills communicate effectively with individuals, groups, communities and organisations on health promotion actions
5.2 Develop written, oral and electronic communication (including reports, presentations and focused messages) that are adapted to specific contexts
5.3 Use the media and current information technologies to receive and disseminate information
5.4 Use effective and culturally appropriate communication methods and techniques for specific groups and contexts
5.5 Use interpersonal communication and groupwork skills to facilitate individuals, groups, communities and organisations to develop personal skills and community action to improve health and reduce health inequities

6. Leadership
Contribute to the development of a shared vision and strategic direction for health promotion actions:

6.1 Use democratic and empowerment leadership skills including active listening, negotiation, team work, motivation, conflict resolution, decision-making, facilitation and problem-solving skills
6.2 Network with and motivate key stakeholders in relevant organisations, including one’s own, in leading change to promote health.
6.3 Reflect on learning and achievement needs at individual and organisational levels to build health promotion capacity
6.4 Incorporate new knowledge and ideas to improve practice and respond to emerging challenges in health promotion
6.5 Mobilise and manage resources for health promotion actions

7. Assessment
Conduct assessment of needs and assets in settings and systems that lead to the identification and analysis of the political, economic, social, cultural, environmental, behavioural and biological determinants that promote or compromise health:

7.1 Identify priorities for health promotion actions in consultation and partnership with key stakeholders, using available evidence and health promotion principles
7.2 Collect, review and critically appraise relevant data, information and literature
7.3 Use a variety of assessment techniques including quantitative and qualitative research methods
7.4 Engage stakeholders in the assessment process
7.5 Use culturally appropriate assessment approaches
7.6 Identify existing assets and resources in individuals, organisations and communities
7.7 Identify political, economic, social, cultural, environmental, behavioural and biological determinants which impact on health
7.8 Identify the key drivers for and barriers to health promotion action

8. Planning
Develop measurable health promotion goals and objectives in response to assessment of needs and assets and identify strategies that are based on knowledge derived from theory, evidence, practice and consultation with stakeholders:

8.1 Use a systematic approach to health promotion action planning
8.2 Develop and communicate appropriate, realistic and measurable goals and objectives
8.3 Identify an appropriate mix of strategies to achieve objectives
8.4 Identify and secure resources (skills, personnel, partner contributions, finance, materials, training and support) for sustainable health promotion action
8.5 Develop a feasible action plan within resource constraints and with reference to existing needs and assets
8.6 Mobilise, support and engage the participation of key stakeholders

9. Implementation
Implement effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources:

9.1 Use culturally relevant and appropriate health promotion implementation approaches
9.2 Use ethical, empowering and participatory processes appropriate to specific contexts
9.3 Develop, pilot and use appropriate programme resources and materials
9.4 Monitor the quality of implementation of programmes in relation to agreed goals and objectives
9.5 Use process evaluation feedback to maintain and improve effective implementation
9.6 Manage the resources needed for effective implementation
9.7 Facilitate programme sustainability and stakeholder ownership through ongoing consultation and collaboration

10. Evaluation and Research
*Determine the reach, effectiveness and impact of health promotion actions. This includes utilising appropriate evaluation and research methods to support programme improvements, sustainability and dissemination:*

10.1 Integrate evaluation into the planning and implementation of all health promotion actions

10.2 Use appropriate health promotion evaluation and monitoring methods and tools in partnership with stakeholders to record process, impact and outcome evaluation

10.3 Use evaluation findings to refine and improve health promotion actions

10.4 Use research and evidence-based strategies to inform practice

10.5 Contribute to the planning, conducting and writing of evaluation initiatives
Glossary

In addition to the terms defined in this glossary, the project uses the definitions from the World Health Organisation’s (WHO) Glossary of Health Promotion (http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf) and in the update (http://heapro.oxfordjournals.org/cgi/reprint/dal033v1.pdf) The wording in some of the definitions has been slightly changed from the original reference to make them more directly relevant to the CompHP Project

Capacity Building: an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. (21)

Competencies: 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. (16)

Competencies as described in health promotion literature:

- Refer not only to the knowledge, but also to the skills and attitudes needed to produce a performance
- Focus on doing and acting so that a competent person not only knows something, but also knows how to do something with what they know
- Have to do with the capacity to face new contexts and respond to new challenges. (22)

Consensus: means overwhelming agreement. It is important that consensus be the product of a good-faith effort to meet the interests of all stakeholders. The key indicator of whether or not a consensus has been reached is that everyone agrees they can live with the final proposal after every effort has been made to meet any outstanding interests. Most consensus processes seek unanimity, but settle for overwhelming agreement that goes as far as possible toward meeting the interests of all stakeholders. It is absolutely crucial that this definition of success be clear at the outset of the process. (23)

Consultation: a tool for managing two-way communications between project developers and stakeholders. The goal is to improve decision-making, reduce risk, and build understanding by actively involving individuals, groups and organisations with a stake in the project. Their involvement increases the project’s long-term viability and enhances its benefits to stakeholders. To be meaningful, consultation should be carried out in a culturally appropriate manner, with locally appropriate timeframes. (24)

Continuing professional development (CPD): refers to study designed to upgrade knowledge and skills of practitioners in the professions. (25)

Core competencies: are the minimum sets 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. (17)
**Delphi Method/technique:** is an iterative process used to collect and distil the judgments of experts using a series of questionnaires interspersed with feedback. Each subsequent questionnaire is developed based on the results of the previous questionnaire. The Delphi method is widely accepted throughout the world in many sectors including health care, defence, business, education, information technology and engineering. (26)

**Experts:** people who have an above average knowledge in a specific field of significance. They usually have experience, training, education, and/or an enthusiasm for the subject being explored. (27)

**Inequity/Inequality:** The concept of **inequity** has been considered synonymous with the concept of **inequality**; however, while inequality implies differences between individuals or population groups, inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. Not all inequalities are unjust, but all inequities are the product of unjust inequalities. The definitions of **just** and **unjust** are subject to various interpretations. In the context of health, one of the more accepted definitions of "just" refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay. (28)

**Partner:** the individual and/or organisation with which one collaborates to achieve mutually agreed upon objectives. (24)

**Partnership:** a collaborative relationship of individuals and/or organisations within which partners set aside personal or organisational agendas to achieve the agenda of the partnership. In a partnership, the partners engage as equals in the decision-making process. In effective partnerships, partners share a vision, are committed to the integrity of the partnership, agree on specific goals, and develop a plan of action to accomplish the goals. (29)

**Stakeholder:** those groups or individuals: (a) that can reasonably be expected to be significantly affected by the project’s activities, products, and/or services; or (b) whose actions can reasonably be expected to affect the ability of the project to successfully implement its strategies and achieve its objectives. They can be an individual, community or organisation that affects, or is affected by, the operations of the project. Stakeholders may be individuals, interest groups, government agencies, or corporate organisations. (24)
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CompHP Core Competencies Framework for Health Promotion Draft 4

Introduction

This framework document presents a set of core competencies for health promotion practice in Europe. The core competency framework outlines the essential knowledge, skills and values necessary for the practice of health promotion. The core competencies were developed as part of a European project entitled ‘Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe’ (CompHP) \(^{13}\), which is funded by the European Agency for Health and Consumers. The CompHP project aims to develop, test and refine a framework for competency-based standards and accreditation for health promotion in Europe. The project employs a consensus building process based on consultation with health promotion practitioners, policymakers and education providers across Europe.

The development process for the CompHP Core Competencies for Health Promotion includes:

- A review of the international and European literature on health promotion competencies (1)
- Initial draft framework of core competencies based on findings from the literature review and consultation with project partners
- Delphi survey on the draft core competencies undertaken with health promotion experts from across Europe to reach consensus\(^ {14}\)
- Focus groups with health promotion experts and other key stakeholders from across Europe
- Consultation with health promotion practitioners, academics, policy makers and employers using an online consultation process

The CompHP project partners and an International Expert Advisory Group advised on each stage of the development process. The CompHP core competencies are, therefore, the result of a wide ranging consultation process and draw on the international and European literature, in particular:

- The domains of core competencies outlined in the Galway Consensus Statement (2), together with the modifications to the statement suggested in a global consultation process

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\(^{13}\) See CompHP Website at [http://www.iuhpe.org/?page=614&lang=en](http://www.iuhpe.org/?page=614&lang=en) for details on the project as a whole and the development process for these core competencies

\(^{14}\) The criteria for inclusion in the sample are 6 representatives from each country, 2 each from the areas of practice, policy and academia based on, in order of priority: national role in health promotion, experience in health promotion, experience in the competency approach.
The core competencies for health promotion developed in Australia (3), Canada (4), New Zealand (5) and the UK (6).

Who are the core competencies for?
The CompHP core competencies are designed for use by health promotion practitioners whose main role and function is health promotion and who have a graduate or post graduate qualification in health promotion or a related discipline15. The competencies will also be useful to those working in other professional areas whose role includes health promotion (e.g. community health).

For the purpose of this document, a health promotion practitioner is defined as a person who works to promote health and reduce health inequities using the actions described by the Ottawa Charter (7):
- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- reorienting health services

While job titles and academic course titles in different countries across Europe may not always include the term ‘health promotion’, the core competencies are designed to be relevant to all practitioners whose main role reflects the Ottawa Charter’s (7) definition and principles of health promotion. Health promotion practitioners require specific education and training along with ongoing professional development to maintain the particular combination of knowledge and skills required to ensure quality health promotion practice.

Defining Core Competencies
The definition of competencies used in this framework is: ‘a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion’ (8). Core competencies are defined as the minimum set of competencies that constitute a common baseline for all health promotion roles, that is; ‘they are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field’ (3).

Uses of Core Competencies for Health Promotion
Health promotion core competencies can be used for a range of purposes including:
- Ensuring that there are clear guidelines for the knowledge, skills and values needed to practice effectively and ethically
- Forming the basis for accountable practice and quality assurance
- Informing education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs

15 Including, for example, public health, social sciences including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, political science. This is not an exclusive list as other academic qualifications may also be deemed as appropriate in given situations.
- Assisting employers and managers to gain a better understanding of health promotion roles in individual workplaces and develop appropriate job descriptions
- Assisting in career planning and identifying professional development and training needs
- Facilitating movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies
- Promoting better communication and team work in multidisciplinary and multisectoral settings by providing a common language and shared understanding of the key concepts and practices used in health promotion
- Contributing to greater recognition and validation of health promotion and the work done by health promotion practitioners

It is recognised that those using the competencies may wish to identify different levels of expertise for some or all of the competencies or to emphasise some competencies to a greater degree than others. For example, the core competencies could form the basis for developing more advanced competencies for practitioners working at senior management level in health promotion and could also be adapted to identify more specialised competencies for health promoters working in more specialised roles.

However, as these are core competencies, all domains should be addressed if they are to be used as the basis for consistent, quality practice which can be recognised internationally and be accredited though a pan-European accreditation system. The core competencies described here should be reviewed and updated in response to changes in contemporary practice.

Core Concepts and Principles Underpinning the CompHP Competency Framework

The competencies are based on the core concepts and principles of health promotion as outlined in the Ottawa Charter (7) and successive WHO charters and declarations on health promotion (9-14). Health promotion is understood to be “the process of enabling people to increase control over, and to improve, their health” (7). The Ottawa Charter embraces a positive definition of health as being, “a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity”. Health is conceptualised as a resource for everyday life, emphasising social and personal resources, as well as physical capacities. Health promotion represents a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also actions directed toward changing social, environmental and economic conditions which impact on health (15). The CompHP core competencies are underpinned by an understanding that health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (17, 18) and that there are well-developed theories, strategies, evidence and values that underpin good practice in health promotion (19).

Within this set of core competencies the term ‘health promotion action’ is used to describe programmes, policies and other organised health promotion interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable and multi-strategy in nature (16) which aim to improve health and reduce health inequities.
The CompHP Core Competency Framework comprises nine domains of core competency, each of which are underpinned by a base of knowledge and ethical values that are integral to the practice of health promotion. It is the combined application of the core competencies integrated with health promotion knowledge and ethical values which constitute the CompHP Competency Framework as illustrated in Figure 1.

Figure 1: Illustration of CompHP Competency Domains
Ethical Values Underpinning Health Promotion Core Competencies
Ethical values and principles for health promotion form the basis for the CompHP Core Competencies. 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 diversity of gender, sexual orientation, age, religion, disability, ethnicity and cultural beliefs
- Addressing health inequities, social injustice, and prioritising the needs of those experiencing poverty and social marginalisation
- Addressing the political, economic, social, cultural, environmental, behavioural and biological determinants of health and wellbeing
- 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 programmes that influence health
- Collaboration and partnership as the basis for health promotion action
- Empowerment of individuals and groups to promote 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.

The knowledge base for the core competencies includes:

- The concepts, principles and ethical values of health promotion as defined by the Ottawa Charter for Health Promotion (7) 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, their impact on and 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 which support empowerment, participation, partnership and equity as the basis for health promotion action
- The current theories and evidence which underpin effective leadership, advocacy and partnership building and their implication for health promotion action
- The current models and approaches of effective project and programme 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 health promotion action
• The systems, policies and legislation which impact on health and their relevance for health promotion

CompHP Core Competency Domains
The domains of core competencies for health promotion practice are:

1. Enable Change
2. Advocate for Health
3. Mediate through Partnership
4. Communication
5. Leadership
6. Assessment
7. Planning
8. Implementation
9. Evaluation and Research

1. Enable Change
Enable individuals, groups, communities and organisations 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 which impact positively on health and reduce health inequities
1.2 Use health promotion approaches which support empowerment, participation, partnership and equity to create environments and settings which 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 organisations 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 which 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 for the development of policies, guidelines and procedures which impact positively 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 who can actively contribute to health promotion action
3.2 Facilitate effective partnership working which reflects health promotion values and principles
3.3 Be aware of different sectoral interests and build successful partnership through collaborative working
3.4 Facilitate the development and sustainability of coalitions and networks for health promotion action

4. Communication
*Communicate health promotion actions 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, non-verbal, listening skills and information technology
4.2 Use electronic 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 organisations 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 on a shared vision and strategic direction for health promotion action
5.2 Use leadership skills which facilitate empowerment and participation (e.g. team work, 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 and ideas to improve practice and respond to emerging challenges in health promotion
5.5 Contribute to mobilising and managing resources for health promotion action
5.6 Contribute to team and organisational 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, behavioural and biological determinants that promote or comprise 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 health needs, existing assets and resources relevant to health promotion action
6.5 Use culturally and ethically appropriate assessment approaches
6.6 Identify the determinants of health which impact on health
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 in partnership with stakeholders based on assessment of needs and assets

A health promotion practitioner is able to:

7.1 Mobilise, support and engage the participation of stakeholders
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
8.4 Facilitate programme sustainability and stakeholder ownership through ongoing consultation and collaboration
8.5 Monitor the quality of the implementation process in relation to agreed goals and objectives
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 evaluation and research processes
Glossary

In addition to the terms defined in this glossary, the project uses the definitions from the World Health Organisation’s (WHO) Glossary of Health Promotion (http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf) and (http://heapro.oxfordjournals.org/cgi/reprint/dal033v1.pdf) The wording in some of the definitions has been slightly changed from the original reference to make them more directly relevant to the CompHP Project.

Capacity Building: an approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors. (20)

Competencies: a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion. (Adapted from 8)

Competencies as described in health promotion literature:

- Refer not only to the knowledge, but also to the skills and values needed to produce a performance
- Focus on doing and acting so that a competent person not only knows something, but also knows how to do something with what they know
- Have to do with the capacity to face new contexts and respond to new challenges. (21)

Consensus: means overwhelming agreement. The key indicator of whether or not a consensus has been reached is that everyone agrees they can live with the final proposal after every effort has been made to meet any outstanding interests. Most consensus processes seek unanimity, but settle for overwhelming agreement that goes as far as possible toward meeting the interests of all stakeholders. (22)

Consultation: a tool for managing two-way communications between project developers and stakeholders to improve decision-making, reduce risk, and build understanding by actively involving individuals, groups and organisations with a stake in the project. To be meaningful, consultation should be carried out in a culturally appropriate manner, with locally appropriate timeframes. (23)

Continuing Professional Development (CPD): refers to study designed to upgrade knowledge and skills of practitioners in the professions. (24)

Core competencies: are the minimum sets 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. (4)

Delphi Method/Technique: is a process used to collect and distil the judgments of experts using a series of questionnaires interspersed with feedback. Each subsequent questionnaire is developed based on the results of the previous questionnaire. The Delphi method is widely
accepted throughout the world in many sectors including health care, defence, business, education, information technology and engineering. (25)

**Experts:** people who have an above average knowledge in a specific field of significance. They usually have experience, training, education, and/or an enthusiasm for the subject being explored. (26)

**Inequity/Inequality:** Inequity refers to differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust. Not all inequalities are unjust, but all inequities are the product of unjust inequalities. The definitions of *just* and *unjust* are subject to various interpretations. In the context of health, one of the more accepted definitions of "just" refers to equal opportunities for individuals and social groups, in terms of granting access to and using the health services, in accordance with the needs of the various groups of a population, regardless of their ability to pay. (27) For more information please see: [http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf)

**Partner:** the individual and/or organisation who collaborates to achieve mutually agreed upon objectives. (23)

**Partnership:** a collaborative relationship of individuals and/or organisations within which partners set aside personal or organisational agendas to achieve the agenda of the partnership. In effective partnerships, partners share a vision, are committed to the integrity of the partnership, agree on specific goals, and develop a shared plan of action to accomplish the goals. (28)

**Right to Health:** this is stated in the *Universal Declaration of Human Rights*, Article 25 in 1948. The article says that "Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family". The Preamble to the WHO constitution also declares that it is one of the fundamental rights of every human being to enjoy "the highest attainable standard of health". For further information please see: [http://www.ohchr.org/Documents/Publications/Factsheet31.pdf](http://www.ohchr.org/Documents/Publications/Factsheet31.pdf)

**Stakeholder:** those communities, groups or individuals who are affected by the project’s activities, products, and/or services or whose actions can affect the ability of the project to achieve its objectives. Stakeholders may be individuals, interest groups, government agencies, or corporate organisations. (23)
References


   [http://www.who.int/healthpromotion/conferences/hpr_special%20issue.pdf](http://www.who.int/healthpromotion/conferences/hpr_special%20issue.pdf)


   [http://www.who.int/healthpromotion/about/HPG/en/](http://www.who.int/healthpromotion/about/HPG/en/)


Appendix 4:

Table 6: Results from Pilot Study

<table>
<thead>
<tr>
<th>Question 1.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you agree that the introduction and background document is clearly presented?</td>
</tr>
</tbody>
</table>

<table>
<thead>
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<th>Respondents</th>
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<td>(10) 76.9%</td>
<td>(2) 15.4%</td>
<td>13</td>
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</tbody>
</table>

Respondents Suggestions

1. I appreciate the way it is done. I just got an opinion that there are some duplications of the information

2. No explanation on the nature of the expert panel neither the international advisory group...

3. Why using the American term competency? I personally prefer competencies (clearly a plural noun)...clearly more inclusive of a set of attributes for those whose English is second-language... of course, they are just terms but as noted in the glossary, the context is not clearly included in any of the definitions and it would be good to have it there as it is in the text

4. I am not happy with the term health inequities - I prefer "inequalities", the term used in the latest EU documents (Commission Communication Solidarity in Health, Together for Health, strategic approach for EU...)

5. ‘Inequities’ is used in several competency statements throughout this document. Inequities are sometimes misinterpreted or confused with inequality. The document would be strengthened by adding these definitions to the glossary.

6. The introduction to the document is clear and easy to follow but recommend that the term ‘entry level’ as while it is clear these competencies are designed for ‘entry level’, the status of what constitutes ‘entry level’ is not so clear. A requirement for graduate or post graduate qualifications for entry into health promotion indicates a ‘high entry point? Practitioners in the field without graduate qualifications could disregard these competencies as not being applicable to them?

7. Several current political regimes continue to deny the existence of indigenous people’s as a collective or political group. There people number about 4% of the global population and many have experienced huge losses and now suffer the worst health status and disparities in their country. Acknowledgement of ‘indigenous peoples’ as described below. ‘Compare to non-indigenous members of the population life expectancy is significantly lower for indigenous peoples and the incidence of most diseases is higher, sometimes by rates of two or three times.’ Quote form Prof Durie, IUHPE conf Melbourne, 2004. Recommend acknowledgement of indigenous people

8. ‘Action’ the document uses several words which may or may not imply the same meaning. These terms include: health promotion action, action on health promotion, strategies, health promotion activities, health promotion programmes, health promotion interventions, programme implementation. Recommend that if these words have the same meaning the document will be easier to understand if only one term is consistently used. If they have different meanings these should be explained in the glossary.

Actions Taken

3. The term competencies will be used.

4 & 5. The term inequity is used in Alma Ata, Ottawa ‘achieving equity, foster greater equity etc’, Adelaide – health & equity ‘inequalities in health are rooted in inequities in society’ Inequity used in 2007 EI white paper We will use inequity in line with global documents but also give it to the glossary using the WHO definitions. http://www.paho.org/english/Sha/be991ineq.htm

We are aware that the term inequality is more widely used in some countries and the glossary will include an explanatory note to this effect.

6. What we mean by entry level will be defined more clearly in the document. This should help clarify also some of the other comments about levels in the feedback.

7. In the European context the term ‘indigenous peoples’ is less clearly understood. However different cultural and ethnic groups, including migrants and asylum seekers do exist and these groups will be included e.g. in Comp 5.1.

8. The document will be reviewed and edited where necessary with this in mind. The glossary will also be reviewed to reflect this.
**Question 2.**  
In relation to the introduction and background document, do you think it is?

<table>
<thead>
<tr>
<th>Too Long</th>
<th>Too Short</th>
<th>About Right</th>
<th>Other</th>
<th>Respondents</th>
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</thead>
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<td>3</td>
<td>1</td>
<td>6</td>
<td>3</td>
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</tbody>
</table>

**Respondents Suggestions**

1. The section 'use of core competencies' is vital, and perhaps should be moved up, or highlighted in some way.

2. Information is general, which may or may not be fine depending on the intended use of the document. Personally I would either keep it as it is for general use but in order to be applicable the scientific/scholarly background should be represented more thoroughly (e.g. references).

3. Too long

**Actions Taken**

1. The purpose and use of the competencies framework will be signposted earlier in the paper.

**Question 3.**  
Do you agree with the content of the Introduction and Background of the Framework document?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
</tr>
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<td>1</td>
<td>1</td>
<td>7</td>
<td>3</td>
<td>13</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Right on, and VERY well done!!

2. Value-based general approach represented in the document is problematic in the sense that it does not always provide content to the definitions and thus they are very general.

3. Very good the section on uses of the core competencies

4. P3 definition - to 'promote the health of populations' - suggest this should include individuals/communities - populations is a public health perspective and is appropriate BUT Ottawa Charter action 'developing personal skills' endorses an individual approach in conjunction with other actions, much hp practice includes individual support to behavioural change. Have not looked at comp's yet, but to discount this aspect could leave a lot of 'behaviour change' workers out of the loop. In fact p16 uses individuals and communities phrasing so this may just be an omission in the definition

5. I anticipate some content will change as the process develops and consensus becomes clearer e.g. comments such as 'are being developed' will become 'were developed'

6. The references not being on the same page was a bit frustrating - a lot of looking backwards and forwards - academics might find this process a bit easier but as a practitioner I found it cumbersome.

**Actions Taken**

3. Individuals, communities and populations will be included.

6. Position of references will remain at the end of the document as is customary in papers of this type.
**Question 4.** Enabling change and empowering individuals and communities to improve their health: Is this domain core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>3</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>

Respondents Suggestions

1. I am sorry, I don't have time to point and click at every one of these. I believe all, right through 10.9, are core to HP practice. Sorry not to be more critical, but having been part of the process, I guess it is understandable that I agree with the outcome!!

2. I would suggest to include to the name of the domain the concept empowerment and label the core domain as follows: Empowering and enabling change.

Actions Taken

1. The domain name will remain as empowering is already in the title.

**Question 5.** 1.1 Enable individuals and communities to improve their health and reduce health inequities through undertaking a variety of health promotion activities including community development and empowerment strategies, advocacy and lobbying, organisational and environmental strategies, mass media strategies and health education

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<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>1</td>
<td>4</td>
<td>7</td>
<td>4.11</td>
</tr>
</tbody>
</table>

Respondents Suggestions

1. I think it is too demanding for entry level health promotion practitioners

2. Variety of health promotion activities should be specified exactly or left open.

3. Health promotion activities - already commented on this in Question 1 on Terms used in Action.

Actions Taken

1. We do use the word ‘including’ which indicates that the list is not meant to be exhaustive.

**Question 6.** 1.2 Contribute to building healthy policy across sectors and at all levels to ensure that health, economic and social policies lead to improved health and reduced health inequity

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<tr>
<th>Strongly Disagree</th>
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<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
<td>7</td>
<td>4.44</td>
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</tbody>
</table>

Respondents Suggestions

1. I would maybe add a dimension about inter sectoral approach to health public policies and creating supportive environments.

2. It is too much for entry level

Actions Taken

1. Changed to “Contribute to building healthy public policy across all sectors and levels to ensure that health, economic and social policies lead to improved health and reduced health inequities.”
### Question 7.

**1.3 Contribute to the creation of supportive environments to improve health and reduce health inequities utilising the settings-based approach**

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<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
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</table>

**Respondents Suggestions**

1. Suggestion: ... utilising relevant strategies including settings-based approach.

2. I prefer inequalities instead of inequities

3. Is the settings-based approach the only valid one? This might be contradictory to 1.1. if all competencies must be included to be qualified as health promotion professional.

4. The ‘settings based approach’ see comment in Question 112

**Actions Taken**

Changed to: “Contribute to the creation of supportive environments to improve health and reduce health inequities using approaches such as the settings-based approach.”

---

### Question 8.

**1.4 Strengthen community action through promoting participatory community development processes, building capacity and capabilities within communities for improving health and engaging with communities based on trust and mutual respect**

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<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
<td>6</td>
<td>4.25</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Excellent

2. I would add the concept of creating a sense of ownership of community processes and programmes.

3. I cannot imagine how to described the competence in more details for practice

4. Participatory processes are not the only ones that strengthen community action; e.g. legislation changes may do so but they do not necessarily qualify as participatory. Does this mean that lobbying alcohol or smoking tax increase is not health promotion? In addition this ties health promotion to very specific contexts yet still remains a bit vague.

**Actions Taken**

Changed to: “Strengthen community action by facilitating community participation and ownership through community development processes, and building capacity within communities for improving health based on mutual trust and respect”.

---

127
**Question 9.**

1.5 Facilitate the development of personal skills by enabling individuals to make healthy choices and access the resources they require to improve health through health education and support for personal change

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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</tbody>
</table>

**Respondents Suggestions**

1. I would go beyond health education and look at other dimensions of health promotion enabling development of personal skills

**Actions Taken**

Changed to: “Facilitate the development of personal skills by enabling individuals to make healthy choices and access the resources they require to improve health through health education and strategies that support personal change”.

---

**Question 10.**

1.6 Contribute to the reorientation of the health service towards health promotion and reducing health inequities through the provision of information, expertise, collaboration and partnership

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<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>2</td>
<td>5</td>
<td>8</td>
<td>4.11</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Contribute to the reorientation of the health service towards health promotion and reducing health inequities through the provision of information, expertise, and collaboration and through engaged multi-sectoral partnerships.

2. The reorientation of health services... is not a competence of health promotion. Reducing health INEQUALITIES ....the meaning of the sentence is not clear to me as well as relation to health services.

**Actions Taken**

2. Reorientation of the health services is a key action are of the Ottawa Charter and for this reason it is appropriate to include it as a core competency.

---

**Question 11.**

Do you think there are any other competencies that should be included in the core domain Enabling Change?

<table>
<thead>
<tr>
<th></th>
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</tr>
</tbody>
</table>

**Respondents Suggestions**

1. The text is often very long and sometimes includes theoretical statements difficult to translate in action

2. Facilitate participation of minorities and migrants in health promotion activities

3. The above statements are rather broad, and do not state how each would be demonstrated. For example, applying change theory in a practical setting.

**Actions Taken**

Some of the points raised here will be addressed in the glossary.
### Question 12.

**Leadership Domain - Providing strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion and building capacity**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
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<th>Agree</th>
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</table>

**Respondents Suggestions**

1. Providing strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion, supporting health promotion programmes and building capacity

2. It is too much for entry level

**Actions Taken**

Changed to: "Contribute to the provision of strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion, supporting health promotion programmes and building capacity".

### Question 13.

**2.1 Demonstrate democratic and empowerment leadership skills reflecting health promotion principles**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Strongly Agree</th>
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<td>1</td>
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<td>8</td>
<td>4.25</td>
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</tbody>
</table>

**Respondents Suggestions**

1. It is important but wouldn’t consider it a core competency. Besides, I have some doubts as to what is meant by this.

2. The principle is very reasonable but the execution is problematic; requirement for leadership indicates that people who work with the practical issues (nurses etc.) do not fit into the scope of these criteria - is this intended?

**Actions Taken**

This item is intended to convey a broader understanding of leadership and its demonstration in core elements of health promotion practice.

### Question 14.

**2.2 Contribute to the development of a vision and strategic direction for health promotion policies and programmes**

<table>
<thead>
<tr>
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<th>Strongly Agree</th>
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<th>Mean</th>
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**Respondents Suggestions**

**Actions Taken**
<table>
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<tr>
<th>Question 15.</th>
<th>2.3 Engage and influence others in and beyond one's own organisation to promote health and address health inequities</th>
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<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. People working with practical issues do not usually fit into this criteria.

**Actions Taken**
Changed to: “Work to influence one’s own and other organisations, and key stakeholders to promote health and address health inequities”.

<table>
<thead>
<tr>
<th>Question 16.</th>
<th>2.4 Lead change in complex Environments through utilising interpersonal skills (negotiation, team work, motivation, conflict resolution, decision making, facilitation and problem solving skills) to promote health and reduce inequities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. If this competency is to be included, could the first word “lead” be changed to “participate”? Or the definition of “lead” made somewhat less ambiguous? If context is not defined this does not work. Example: CompHP project has a leader and several people working on it. Only the project leader fulfils this criteria if “leading” is understood as a position/final decision maker etc.
2. This statement requires very advanced skills for ‘core’ competency level – recommend removing from this sentence the words ‘complex environments’ and ‘conflict resolution’.

**Actions Taken**
Changed to: “Demonstrate leadership in facilitating change through utilising interpersonal skills (negotiation, team work, motivation, conflict resolution, decision making, facilitation and problem solving skills) to promote health and reduce inequities”.

<table>
<thead>
<tr>
<th>Question 17.</th>
<th>2.5 Build and maintain capacity in individuals, teams, groups and communities to support the development and implementation of health promotion policies and programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strongly Disagree</td>
<td>Disagree</td>
</tr>
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</tr>
</tbody>
</table>

**Respondents Suggestions**
1. Build and maintain capacity in individuals, teams, groups and communities to support the development and implementation of health promotion policies and programmes and to ensure sustainability.

**Actions Taken**
Changed to: “Build and maintain capacity in individuals, teams, groups and communities to support the development and implementation of sustainable health promotion policies and programmes”.
### Question 18. 2.6 Mobilise and manage resources for effective and efficient health promotion programmes and policies

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<td>1</td>
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<td>7</td>
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</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This leaves certain professions/activities out.

**Actions Taken**

This will be addressed in the framework document.

### Question 19. 2.7 Contribute to the development and implementation of evidence-based policies, procedures, guidelines and protocols for health promotion

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Respondents</th>
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</tbody>
</table>

**Respondents Suggestions**

1. Ensuring both top-down and bottom-up approaches are considered
   - engage different sectors of governments to share responsibility for promoting the health of the whole school community, to create supportive and sustainable infrastructures and to encourage action at the national, sub-national, regional and local levels;
   - Influence policies to be healthy public policies by showcasing good practice of culturally adapted, evidence-based, and highly participatory and empowering interventions and adopting a sustainable whole school approach to promoting the physical, mental, social and environmental health of present and future generations

2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

1. Some of these points are already captured and reflected in other competency statements.
   Changed to: “Contribute to the development and implementation of ethical and evidence-based policies, procedures, guidelines and protocols for health promotion”.
### Question 20.

#### 2.8 Synthesise new knowledge into the development of health promotion policies and practice to improve health and reduce health inequities

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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</table>

**Respondents Suggestions**

1. Synthesise new knowledge and processes into the development of health promotion policies and practice to improve health and reduce health inequities

2. It is not task for HP practitioners. The formulation above is better

3. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

Changed to: “Synthesise new knowledge and processes into the development of health promotion policies and practice to improve health and reduce health inequities”.

### Question 21.

#### 2.9 Engage in reflective practice and take action to identify and meet learning and development needs at individual and organisational levels

<table>
<thead>
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<td>3</td>
<td>4</td>
<td>7</td>
<td>4.57</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. ... and community level ...

**Actions Taken**

We are referring to professional development which takes place at an individual and/or organisational levels, therefore the term community will not be included.

### Question 22.

#### Do you think there are any other competencies that should be included in the core domain Leadership?

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>(3) 28.6%</td>
<td>(5) 71.4%</td>
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</table>

**Respondents Suggestions**

1. The text is sometimes long and sometimes includes theoretical statements (like “Engage in reflective practice”) difficult to translate in action

2. Engage and influence stakeholders from other sectors is already covered in other competencies.

3. Are these entry level competencies or more advanced practice?
### Question 23.
**Assessment Domain. Conducting assessment of needs and assets in settings and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental and organisational determinants that promote or compromise health**

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td></td>
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</tbody>
</table>

**Respondents Suggestions**

1. ... and political determinants ...
2. This is too demanding if taken literally.
3. The use of terms ‘health promotion action’ and ‘action on health promotion as commented on in Question 1.

**Actions Taken**

Changed to: “Conducting assessment of needs and assets in settings and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental, organisational and political determinants that promote or compromise health”.

### Question 24.
**3.1 Collect and critically appraise relevant data, information and literature for health promotion policies and programmes from primary and secondary sources using a variety of methods**

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<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
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</table>

**Respondents Suggestions**

1. Collect, review and critically appraise ...
2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

Changed to: “Collect, review and critically appraise relevant data, information and literature for health promotion policies and programmes from primary and secondary sources using a variety of research methods including social science and epidemiological methods”.

### Question 25.
**3.2 Identify and involve community members and other stakeholders in health promotion assessment processes**

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<thead>
<tr>
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<th>Agree</th>
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<th>Respondents</th>
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</table>

**Respondents Suggestions**

1. I strongly agree that this is a core competency, but I would like to discuss about the opportunity to include it in the assessment domain (alternative leadership or enabling change)
2. Highlighting community-based participatory approaches as central to successful and sustainable programmes.

**Actions Taken**

2. This is already captured in the other competencies.
### Question 26.

**3.3 Identify and apply culturally relevant and appropriate health promotion assessment approaches for people from diverse cultural, socioeconomic and educational backgrounds and of all ages, genders, health status, abilities and sexual orientation**

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<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
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<th>Strongly Agree</th>
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<td>4.43</td>
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</tbody>
</table>

**Respondents Suggestions**
1. Identify and apply culturally relevant, appropriate and adapted/tailored health promotion assessment approaches
2. This is too demanding.

**Actions Taken**
Changed to: “Identify, adapt and apply culturally relevant and appropriate health promotion assessment approaches for people from diverse cultural, socioeconomic and educational backgrounds and of all ages, genders, health status, abilities and sexual orientation”.

### Question 27.

**3.4 Identify existing assets and resources which can support action on health promotion**

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Respondents</th>
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<td>4.57</td>
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</tbody>
</table>

**Respondents Suggestions**
1. Maybe assets and resources in the community and organisations
2. Identify existing assets and resources at all levels (community, local authorities, clinics and primary care services, etc...) which can support action on health promotion

**Actions Taken**
Changed to: “Identify existing assets and resources at all levels in organisations and communities which can support action on health promotion to improve health and reduce health inequities”.

### Question 28.

**3.5 Identify the behavioural, environmental, social, cultural and organisational factors which may act as barriers and/or drivers for health promotion action**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>7</td>
<td>4.57</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. I strongly agree that this is a core competency, but I would add biological factors (crucial to involve public health professionals)

**Actions Taken**
Changed to: "Identify the environmental, social, cultural, organisational, behavioural and biological factors which may act as barriers to or drivers for health promotion action".
**Question 29.**

3.6 Assist populations, communities and groups to identify and articulate their experiences of health needs and capacities for health promotion action

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>5</td>
<td>7</td>
<td>4.43</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. clarify the similarities / differences between capacities here and assets and resources in the previous question
2. ... using participatory and empowering approaches.
3. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**
Changed to: “Assist populations, communities and groups to articulate their experiences of health needs and to identify capacities for health promotion action”.

**Question 30.**

3.7 Determine priorities for health promotion interventions based on consultation with key stakeholders, available evidence and health promotion principles

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>4</td>
<td>7</td>
<td>4.14</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. I agree there is a competency in determine priorities, but this statement seems too top-down: catalyze prioritisation process and partnership with stakeholders would be more appropriate
2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**
Changed to: “Identify priorities for health promotion interventions based on consultation and in partnership with key stakeholders, available evidence and health promotion principles.”
Question 31. Do you think there are any other competencies that should be included in the core domain Assessment?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
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<td>4</td>
</tr>
</tbody>
</table>

Respondents Suggestions: 1. Maybe it would be useful to make explicit the need for a competency in data analysis based on statistical and epidemiological skills. Critically appraise the practice and policy implications of quantitative and qualitative data derived from the assessment contribute to the advancement of health promotion knowledge and practice through the use of research and evidence-based strategies.

2. P8 Assessment - definition in italics - not sure this adequately captures the Identification of health needs - reading it one way might suggest that public health/epidemiology assesses the health status of populations - while health promoters assess the determinants listed. If that’s the case and expectation of the competence then it will imply a distinction between PH / HP and the absolute need for working collaboratively - this may be what is meant and if so should be stated, otherwise there is a gap. Epidemiological assessment if essential, as is the analysis of systems/structures etc that determine it...I do not yet have a sense of whether this project intends to carve out any 'blue water' between the professions.....However very much like the emphasis on assets as well as needs

Actions Taken: 1. Competency 3.1 now addresses this point.

2. The expectation is that health promotion practitioners should have an understanding of both quantitative and qualitative research skills and that needs assessment would draw on a range of different types of data from both epidemiological surveys, focus groups and interviews etc. It may not be helpful at this stage to try to make any further differentiation along these lines until we receive further feedback from the Delphi round.

Question 32. Planning Domain. Developing measurable health promotion 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

<table>
<thead>
<tr>
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<th>Uncertain</th>
<th>Agree</th>
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<td>5</td>
<td>7</td>
<td>4.57</td>
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</tbody>
</table>

Respondents Suggestions: 1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

2. This domain refers to health promotion intervention - see my comment on Action Question 1.

Actions Taken: Will address comment re plethora of terms – interventions, actions, programmes etc. and will edit accordingly in the background the document. Terminology to be checked against WHO charters.
**Question 33. 4.1 Develop comprehensive and sequential intervention plans based on an appropriate needs assessment, current theory and available evidence of effective health promotion practice**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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</tbody>
</table>

**Respondents Suggestions**

1. assessment of needs and assets
2. available evidence, lessons learned, recommendations and good practice examples
3. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.
4. ‘current theory’ which I’m guessing is just a mistake, as we need to draw upon a range of theories, past and present.

**Actions Taken**

Changed to: “Develop comprehensive and sequential plans based on an appropriate assessment of needs and assets, theory and available evidence of effective health promotion practice”.

**Question 34. 4.2 Analyse health promotion approaches, methods and plans for their acceptability to diverse population groups**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

Changed to: “Review health promotion approaches, methods and plans for their acceptability to diverse population groups”.

**Question 35. 4.3 Select an appropriate mix of strategies to achieve objectives based on consultation with stakeholders and available evidence of effective health promotion interventions**

<table>
<thead>
<tr>
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<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<td>4</td>
<td>7</td>
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</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This statement seems too top-down:
   - identify instead of select
   - partnership instead of consultation
2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

Changed to: “Identify an appropriate mix of strategies to achieve objectives based on consultation with stakeholders and available evidence of effective health promotion interventions”.
### Question 36. 4.4 Formulate and communicate appropriate, realistic and measurable goals and objectives for health promotion interventions

<table>
<thead>
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<td>4.63</td>
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</table>

**Respondents Suggestions**
1. Using adapted measurement methods that are able to evaluate complex health promotion interventions

**Actions Taken**
This competency refers more particularly to formulating the objectives rather than measuring them per se.

### Question 37. 4.5 Identify the resources (skills, personnel, partner contributions, finance, materials, training and support) available and those required to develop, implement and evaluate sustainable health promotion interventions

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
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<th>Respondents</th>
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<td>5</td>
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</table>

**Respondents Suggestions**
1. This duplicates a bit paragraph 3.4

### Question 38. 4.6 Develop an action plan and adequate budget to implement effective health promotion interventions

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
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<th>Agree</th>
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<th>Respondents</th>
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<td>5</td>
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<td>4.5</td>
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</table>

**Respondents Suggestions**
1. Develop a realistic action plan and an adequate budget to implement effective health promotion interventions

**Actions Taken**
Changed to: “Develop a feasible action plan and an adequate budget to implement effective health promotion interventions”.

### Question 39. 4.7 Mobilise support and engage the participation of key stakeholders in health promotion programme development, planning and implementation

<table>
<thead>
<tr>
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<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>6</td>
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</tbody>
</table>

**Respondents Suggestions**
1. I strongly agree that this is a core competency, but I would like to discuss about the opportunity to include it in the assessment domain (alternative leadership or enabling change)

**Actions Taken**
The mean score and strong agreement here would suggest that we should leave in this domain but with a slight change.
Changed to: “Mobilise support and engage the participation of key stakeholders in health promotion programme and policy development, planning and implementation”.
**Question 40. 4.8 Develop evaluation plans for assessing the process, impact and outcomes of interventions based on health promotion principles and consultation with key stakeholders**

<table>
<thead>
<tr>
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</tbody>
</table>

**Respondents Suggestions**

1. Partnership instead of consultation
2. maybe it’s more appropriate for evaluation domain

**Actions Taken**

Integrate evaluation into project planning stage through project completion.

The mean score and strong agreement here would suggest that we should leave this as is with minor edit. Changed to: "Develop evaluation plans to assess the process, impact and outcomes of interventions based on health promotion principles and in consultation with key stakeholders.”

---

**Question 41. 4.9 Develop effective feedback mechanisms within process evaluation to ensure that health promotion interventions are being implemented as intended and that contingency plans for programme improvement are in place**

<table>
<thead>
<tr>
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</table>

**Respondents Suggestions**

**Actions Taken**

Changed to: “Develop effective feedback mechanisms as part of the evaluation process to ensure that health promotion interventions are being implemented as intended and that contingency plans for programme improvement are in place”.

---

**Question 42.** Do you think there are any other competencies that should be included in the core domain Planning?

<table>
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<th>Yes</th>
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<td>(7)</td>
<td>87.5%</td>
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</tbody>
</table>

**Respondents Suggestions**

**Actions Taken**

1. Similar to number 33 but more specifically highlight that interventions are based on a number of validated theories and models when planning, implementing and evaluating research.

Reflected in the Knowledge domain

---

**Question 43. Implementation domain. Carrying out effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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</table>

**Respondents Suggestions**

**Actions Taken**

1. There exist very little evidence and/or scientific facts about this; e.g. cultural sensitivity is a nice principle but tends to be impossible in practice except with (national) sub-cultures.

2. See comment in question 1 regarding Action here it refers to ‘programme implementation’

1. Unlikely to be general agreement with this point.

2. See response to Q10 above.
**Question 44.** 5.1 Apply culturally relevant and appropriate health promotion approaches for people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, abilities and sexual orientation

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<th>Strongly Disagree</th>
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</table>

**Respondents Suggestions**

1. Apply culturally relevant and appropriate health promotion approaches for people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, ethnic groups, health status, abilities and sexual orientation.

2. 'Apply' - while the competency clearly emphasises the sensitivity of the approaches, a key element of HP is the participatory approach. The word 'apply' smacks of 'doing to' rather than 'doing with' - it is not intended but has jumped out at me! Could reword 'Use......with people....'

**Actions Taken**

Changed to: “Use culturally relevant and appropriate health promotion approaches for diverse cultural, socioeconomic and educational groups, and for persons of all ages, genders, sexual orientation, ethnicity, health status, and abilities”.

---

**Question 45.** 5.2 Develop and pilot health promotion programme resources and materials

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<th>Uncertain</th>
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</tbody>
</table>

**Respondents Suggestions**

1. Could add reference to development in collaboration/participation with individuals/communities

**Actions Taken**

Changed to: “Develop, pilot and use appropriate health promotion programme resources and materials in collaboration with stakeholder groups”.

---

**Question 46.** 5.3 Implement health promotion strategies using ethical, empowering and participatory processes appropriate to the context of specific settings

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<td>4.57</td>
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</tbody>
</table>

**Respondents Suggestions**

Recommend removing the word ‘settings’ and change to ‘Implement health promotion programmes strategies and policies using ethical, empowering, and participatory processes appropriate to the specific context’

**Actions Taken**

Changed to “Implement health promotion strategies using ethical, empowering and participatory processes appropriate to specific contexts”.
### Question 47. 5.4 Monitor the quality and quantity of health promotion programme implementation

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<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
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<th>Respondents</th>
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<td>4</td>
<td>7</td>
<td>4.43</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Is this a competency in the implementation domain?

2. Ensure qualitative and quantitative monitoring of health promotion programme implementation

**Actions Taken**

Changed to: “Ensure that the quality of implementation of health promotion programmes is monitored and meets agreed goals and objectives”.

### Question 48. 5.5 Use feedback from process evaluation to maintain and improve the effective implementation of planned health promotion interventions

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<th>Strongly Disagree</th>
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<th>Agree</th>
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<th>Respondents</th>
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</table>

**Respondents Suggestions**

1. Partnership instead of consultation

2. maybe it’s more appropriate for evaluation domain Integrate evaluation into project planning stage through project completion

**Actions Taken**

The mean score and strong agreement here would suggest that we should leave this as is with minor edit. Changed to: "Develop evaluation plans to assess the process, impact and outcomes of interventions based on health promotion principles and in consultation with key stakeholders”

### Question 49. 5.6 Manage resources, including the necessary staffing, skills and budgets needed for the effective implementation of health promotion interventions

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<th>Strongly Disagree</th>
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<th>Uncertain</th>
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</table>

**Respondents Suggestions**

1. It too demanding for entry level

2. This leaves certain professions/activities out.

**Actions Taken**

Staff at all levels are required to manage resources, including their own time and skills.

### Question 50. 5.7 Facilitate programme ownership and the sustainability of effective health promotion interventions through ongoing consultation and collaboration with key stakeholders

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<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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</tbody>
</table>

**Respondents Suggestions**

1. this competency is covered in partnership

2. This leaves certain professions/activities out.

**Actions Taken**

Unchanged as this refers specifically to the implementation process.
**Question 51.** Do you think there are any other competencies that should be included in the core domain Implementation?

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<td>12.5%</td>
<td>(7) 87.5%</td>
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</table>

**Respondents Suggestions**

Recommend the addition of specific competencies that prioritise the health needs of, and working with minority and disadvantaged populations including the indigenous peoples of Europe, other ethnic populations, children and people with disabilities.

**Actions Taken**

See Comp 5.1

---

**Question 52.** Evaluation and Research Domain

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

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<thead>
<tr>
<th>Strongly Disagree</th>
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</tbody>
</table>

**Respondents Suggestions**

1. In my experience it is very difficult to separate assessment, evaluation and research. Many competencies are common

2. This strongly indicates certain view of health promotion competencies; e.g., it looks like only people with academic background who work in politics can be considered

3. Comment on terminology in Question 1 – in this domain

6.1 and 6.6 refer to activities

6.4 interventions

6.6 strategies

**Actions Taken**

The mean score and strong agreement here would suggest that we should leave this where it is.

---

**Question 53.** 6.1 Incorporate evaluation into the planning and implementation of all health promotion activities

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<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
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</table>

**Respondents Suggestions**

1. maybe we do not need to put evaluation competencies in "planning" and "implementation"
### Question 54.

**6.2 Engage with research experts on the development and application of research methods for monitoring and evaluation based on appropriate research designs, health promotion principles and ethics**

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<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
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**Respondents Suggestions**

1. This is not a competency. Research expert is unclear for me
2. The other competencies seem to indicate that the person is already an all-powerful expert if s/he meets the competency criteria. As such this is unnecessary - there should probably be a clear goal for the competency list (e.g. what is health promotion as a competency/profession) before setting core competencies.
3. ‘Engage with research experts’ might be revised to read ‘evaluation experts’ but in any case this item is a task, not a competence.

**Actions Taken**

Changed to: “Identify the need for, and engage with technical and research expertise as required to develop and apply research methods for monitoring and evaluation”.

### Question 55.

**6.3 Apply health promotion evaluation and monitoring methods to incorporate process, impact and outcome measurement, facilitating the participation of stakeholders**

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<tr>
<th>Strongly Disagree</th>
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</table>

**Respondents Suggestions**

1. ... facilitating the participation of stakeholders and empowering them.

**Actions Taken**

Changed to: “Use appropriate health promotion evaluation and monitoring methods incorporating process, impact and outcome measurement, in partnership with stakeholders”.

### Question 56.

**6.4 Apply evaluation findings to refine and improve health promotion interventions and support the sustainability and dissemination of effective practice**

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<tr>
<th>Strongly Disagree</th>
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<th>Agree</th>
<th>Strongly Agree</th>
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</table>

**Respondents Suggestions**

1. this competency is covered in partnership
2. This leaves certain professions/activities out.

**Actions Taken**

Unchanged as this refers specifically to the implementation process.
**Question 57.** 6.5 Communicate evaluation findings to stakeholders using language appropriate for diverse audiences

<table>
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<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Respondents</th>
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<td>3</td>
<td>7</td>
<td>4.29</td>
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</tbody>
</table>

Respondents Suggestions

1. Language appropriate for diverse audiences could be expressed better
2. Too demanding in practice.

Actions Taken

Changed to: “Communicate clearly evaluation findings to diverse stakeholder groups”.

**Question 58.** 6.6 Critically appraise the practice and policy implications of quantitative and qualitative data derived from the monitoring and evaluation of health promotion activities

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<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
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<th>Respondents</th>
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</table>

Respondents Suggestions

1. This point could be added in assessment
2. Not at entry level
3. Health promotion claims to be multi-disciplinary. This competency indicates that only certain scientific methods are acceptable and narrows the scope to social sciences (qualitative research is not used widely).

Actions Taken

Changed to: “Critically consider the practice and policy implications of findings from the monitoring and evaluation of health promotion activities”.

**Question 59.** 6.7 Contribute to the advancement of health promotion knowledge and practice through the use of research and evidence-based strategies

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<th>Agree</th>
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<th>Respondents</th>
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</table>

Respondents Suggestions

1. This point could be added in assessment
2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

Actions Taken

The mean score and strong agreement here would suggest that we should leave this where it is.
### Question 60

**6.8 Plan, conduct and write up health promotion evaluation initiatives and prepare research proposals for funding**

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<th>Strongly Disagree</th>
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<th>Strongly Agree</th>
<th>Respondents</th>
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**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

Changed to: “Contribute to planning, conducting and writing health promotion evaluation initiatives and preparing research proposals for funding”.

### Question 61

**6.9 Critically analyse and disseminate relevant health promotion research and literature**

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<th>Strongly Disagree</th>
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<td>4</td>
<td>7</td>
<td>4.14</td>
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</table>

**Respondents Suggestions**

1. to ensure findings reach desired target groups as well as actors outside the field of health promotion
2. Not at entry level
3. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

Changed to: “Review and disseminate relevant health promotion research and literature”.

### Question 62

Do you think there are any other competencies that should be included in the core domain Evaluation and Research?

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<td>(7) 87.5%</td>
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**Respondents Suggestions**

1. Could this be combined with assessment to form a more loose criteria that would incorporate people working with practical matters?
2. ‘Research’ has been annexed to the Galway Consensus domain of ‘Evaluation’. The meaning outlined is solely related to evaluative research, and does not cover any research which would contribute to theory or policy, or indeed to explore promising practice solutions. In other words, it does not cover the importance of practitioners being able to do research, which they currently learn to do in their professional training.

**Actions Taken**

This domain has put emphasised more the role of health promotion practitioners in utilising and applying research both in assessment, implementation and evaluation rather than as health promotion researchers per se. The individual statement items have sought to capture this research function as part of practice.
### Question 63. Advocacy Domain
**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**

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**Respondents Suggestions**
1. This competency is covered in partnership
2. This leaves certain professions/activities out.

**Actions Taken**
Unchanged as this refers specifically to the implementation process.

### Question 64. 7.1 Identify and create opportunities to advocate for and with individuals, groups, communities and organisations on promoting their health and addressing health inequities

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<th>Uncertain</th>
<th>Agree</th>
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<td>4</td>
<td>7</td>
<td>4.57</td>
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</table>

**Respondents Suggestions**
1. Inequalities
2. Could health inequities be left out? Perhaps too much is included in this one competency criteria.

**Actions Taken**
Changed to: “Identify and create opportunities to advocate for and with individuals, groups, communities and organisations to improve health and address health inequities”.

### Question 65. 7.2 Identify strategic alliances and mechanisms for advancing health promotion policy and practice

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<td>4.29</td>
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</table>

**Respondents Suggestions**
1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**
**Question 66.** Identify and critique opposing arguments relating to health promotion and develop strategies to address them

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<th>Respondents</th>
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<td>3.71</td>
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</table>

**Respondents Suggestions**
1. Opposing arguments?
2. Not at entry level

**Actions Taken**
Changed to: “Identify critiques of health promotion and develop strategies to respond to them.”

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**Question 67.** Develop, implement and evaluate advocacy plans for health promotion using a range of advocacy strategies and techniques

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<tr>
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**Respondents Suggestions**
1. Such strategies could be outside the usual actors (e.g. for physical activity promotion - use a tool developed for promoting health in schools), etc...
2. How does this differ from evaluation & assessment (e.g. is there overlap)?

**Actions Taken**

---

**Question 68.** Raise awareness and influence public opinion on health promotion by identifying and accessing relevant media and disseminating a range of resources and information

<table>
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<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4.57</td>
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</table>

**Respondents Suggestions**
1. Widely disseminating
2. Too demanding, narrows scope: there also is a problem that people working in academic fields of health promotion (to whom most of the competencies defined seem fitting) rarely have competency in this; it looks like there is not a single health promotion professional in the world who can have all these core competencies.

**Actions Taken**
It is common practice for academics to relate to the media on research findings.
### Question 69

**7.6 Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non governmental organisations) on the development and implementation of health promotion policies and programmes**

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<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>4.57</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

This type of engagement is integral to health promotion practice.

### Question 70

**7.7 Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>2</td>
<td>3</td>
<td>7</td>
<td>4.14</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

### Question 71

**7.8 Ensure processes are in place to enable and support communities in the articulation of their views and concerns about health promotion and health inequities**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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</tr>
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<tbody>
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<td>2</td>
<td>4</td>
<td>7</td>
<td>4.0</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. No at entry level
2. This leaves certain professions/activities out.
3. How do you "ensure processes are in place"? Could this one be modified "To enable and support communities..."?

**Actions Taken**

Changed to: "Enable and support communities in the articulation of their views and concerns about health and health inequities".

### Question 72

**7.9 Contribute to influencing and shaping organisational, multiagency, regional and national agencies to maximise opportunities for health promotion and reduce health inequities**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>1</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>4.29</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

This type of engagement is integral to health promotion practice.
### Question 73
**Provide health promotion input into policies and strategies which impact on health and health inequities**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>2</td>
<td>7</td>
<td>3.86</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. maybe it is a result of previous competencies
2. policies (urban planning, environment, nutrition, housing, health, e 
   Education, economy, etc...)
3. This strongly indicates certain view of health promotion competencies; e.g. it looks like only 
   people with academic background who work in politics can be considered health promotion 
   professionals.

**Actions Taken**
2. Inclusion of these examples could make this sentence more complex.

### Question 74
**Advocate for the development of policies, guidelines and procedures which impact favourably on health and reduce health inequities**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>1</td>
<td>3</td>
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<td>3.86</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. Maybe it is a result of previous competencies
2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only 
   people with academic background who work in politics can be considered health promotion 
   professionals.

**Actions Taken**
Combined 7.10 and 7.11 as follows: “Advocate for the development of policies, guidelines and 
procedures which impact favourably on health and reduce health inequities and provide health 
promotion input into their development “.

### Question 75
**Do you think there are any other competencies that should be included in the core domain Advocacy?**

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<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(0)</td>
<td>0.0%</td>
<td>(8) 100%</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

**Actions Taken**
### Question 76

**Partnership Domain** Working collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion programmes and policies

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>1</td>
<td>5</td>
<td>7</td>
<td>4.57</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. I see a strong linkage with leadership
2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.
3. Edit for consistency with other statements: Work collaboratively across disciplines...

**Actions Taken**

Changed to: “Work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion programmes and policies”.

### Question 77

**8.1 Identify partners within and outside the health sector with the potential to support the development and implementation of health promotion policies and programmes**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
<td>7</td>
<td>4.43</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

### Question 78

**8.2 Facilitate intersectoral collaboration and build partnerships for health promotion using leadership, team building, negotiation and conflict resolution skills**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
<td>7</td>
<td>4.43</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.
### Question 79. 8.3 Establish and maintain effective partnership working with key health promotion stakeholders, including statutory bodies, community groups and voluntary/non-governmental organisations

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
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<td>4.43</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. Public and private sectors

**Actions Taken**
This type of engagement is integral to health promotion practice.

2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

### Question 80. 8.4 Develop and sustain local, regional and national coalitions and networks for advancing intersectoral health promotion policies and programmes

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4.00</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. Not for practitioner - entry level

2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**

### Question 81. 8.5 Mediate between different sectoral interests and manage the collaborative process in the development and implementation of health promotion policies and programmes

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Respondents</th>
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<td>3</td>
<td>3</td>
<td>7</td>
<td>4.14</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. Not for practitioner at entry level

**Actions Taken**
Changed to: "Mediate between different sectoral interests and manage the partnership process in the development and implementation of health promotion policies and programmes".
### Question 82. 8.6 Review the effectiveness of partnerships and collaborative working for health promotion and make recommendations for improvements as required. BBK

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
<td>7</td>
<td>4.43</td>
</tr>
</tbody>
</table>

#### Respondents Suggestions

#### Actions Taken

### Question 83. Do you think there are any other competencies that should be included in the core domain Partnership?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) 12.5%</td>
<td>(7) 87.5%</td>
</tr>
</tbody>
</table>

#### Respondents Suggestions

1. Involve representative of target groups (seniors, migrants etc. organisation) into partnership on special targeted HP programmes

#### Actions Taken

Glossary will include definition of stakeholders.

### Question 84. Communication Domain Communicating health promotion activities and programmes effectively using appropriate methods for diverse audiences

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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</thead>
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<td>1</td>
<td>5</td>
<td>7</td>
<td>4.57</td>
</tr>
</tbody>
</table>

#### Respondents Suggestions

1. Linkage with advocacy

#### Actions Taken

### Question 85. 9.1 Communicate and disseminate data and information on health promotion policies and programmes to a range of diverse audiences

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>5</td>
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<td>4.43</td>
</tr>
</tbody>
</table>

#### Respondents Suggestions

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

#### Actions Taken

### Question 86. 9.2 Use the media, advanced technologies and relevant networks to receive and communicate information and health promotion

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>2</td>
<td>5</td>
<td>7</td>
<td>4.71</td>
</tr>
</tbody>
</table>

#### Respondents Suggestions

1. Capitalising on the technological advances of globalisation to reach more and a broader range of people.

#### Actions Taken

Advanced technologies captures this point.
### Question 87.

9.3 Develop and disseminate written, oral and electronic communication (including reports, presentations and targeted messages) on health promotion policies and programmes tailored to diverse contexts and settings

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>2</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>4.29</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

2. refers to ‘targeted messages’. Target implies doing ‘to’ or ‘at’ people and conflicts with the supportive, collaborative and principled intent of health promotion. Recommend that targeted messages be changed to either ‘specific or focused messages’ Also refers to ‘diverse context and settings – see previous comments on settings.

**Actions Taken**

Changed to: “Develop and disseminate written, oral and electronic communication (including reports, presentations and focused messages) on health promotion policies and programmes tailored to specific contexts”.

---

### Question 88.

9.4 Use effective and culturally appropriate health promotion communication methods, techniques and language suitable for specific population groups

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>2</td>
<td>5</td>
<td>7</td>
<td>4.71</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. The idea is sound, but will it work in practice?

---

### Question 89.

9.5 Apply interpersonal communication and groupwork skills to facilitate individuals, groups and communities to increase control over their health and reduce health inequalities

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
<td>7</td>
<td>4.29</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This leaves certain professions/activities out.

**Actions Taken**

Changed to: Apply interpersonal communication and groupwork skills to facilitate individuals, groups and communities to increase control over their health and reduce health inequities This was changed for consistency
Question 90. 9.6 Apply a range of communication skills to facilitate the development of personal skills and community action for health promotion

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>1</td>
<td>5</td>
<td>7</td>
<td>4.57</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. This does not define the content it tries to do. What range, what skills?

**Actions Taken**
Changed to: “Apply a range of communication skills to facilitate the development of personal skills and community action to improve health and reduce health inequities”.

---

Question 91. 9.7 Promote and debate the merits of health promotion strategies using evidence-based arguments

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>4.29</td>
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</tbody>
</table>

**Respondents Suggestions**
1. Evidence-based or value-based health promotion?

**Actions Taken**
Changed to: “Promote and debate the merits of diverse health promotion strategies using ethical, theoretical and evidence-based arguments”.

---

Question 92. Do you think there are any other competencies that should be included in the core domain Communication?

<table>
<thead>
<tr>
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<th>No</th>
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<tbody>
<tr>
<td>(2) 25%</td>
<td>(6) 75%</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**
1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

**Actions Taken**
This type of engagement is integral to health promotion practice.
### Question 93. Knowledge Competencies

Demonstrate an understanding of, and the ability to apply in practice, the theory, research and ethical dimensions of health promotion and the multidisciplinary knowledge base which underpins the competencies listed above

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>1</td>
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</tr>
</tbody>
</table>

**Respondents Suggestions**

1. In my opinion we need to clarify the general meaning of this domain

2. Is it basic knowledge of principles, theories and methods?

3. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.

4. It seems odd to have a separate ‘knowledge’ domain, as other domains also require underpinning knowledge.

5. This domain name is notably different as Competencies appears in this domain name.

**Actions Taken**

Await further feedback from the Delphi round before removing the Knowledge domain given the high mean level rating.

Will remove competencies from the title.

---

### Question 94.

10.1 Appreciation of the history and development of health promotion, including the Ottawa Charter (WHO, 1986) and successive charters and declarations, which provide the foundations for health promotion practice

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>4.43</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. and advocate for new charters and revisions of key documents

2. Appreciation is not measurable. Perhaps another word to demonstrate the ability to do this

3. As these competencies are designed for use across a number of countries this statement could be strengthened by making it clear that it applies to both global and national context.

Recommend adding to the end of the sentences ‘in both global and national context.

**Actions Taken**

Changed to: “Demonstrate knowledge of the history and development of health promotion internationally, including the Ottawa Charter (WHO, 1986) and successive charters and declarations, as the foundations for health promotion practice”.

---

### Question 95.

10.2 Understanding of the core concepts and principles of health promotion and their application in practice

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>6</td>
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</table>

**Respondents Suggestions**

1. Understanding is not measurable. Perhaps another word to demonstrate the ability to do this.

**Actions Taken**

Changed to: “Demonstrate understanding of the core concepts and principles of health promotion and their application in practice”.

---
### Question 96.

**10.3 Understanding of the theories, research and multidisciplinary knowledge base underpinning health promotion and their application in the development and implementation of health promotion practice, policy and research**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>3</td>
<td>0</td>
<td>4</td>
<td>7</td>
<td>3.71</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. too general
2. Not at entry level
3. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.
4. Understanding is not measurable. Perhaps another word (e.g., apply) to demonstrate the ability to do this.
5. Multidisciplinary is broad, undefined and open to interpretations. Recommend that it be explained in the glossary

**Actions Taken**

Changed to: “Demonstrate understanding of the theories, research and multidisciplinary knowledge base underpinning health promotion and their application in the development and implementation of health promotion practice, policy and research”.

### Question 97.

**10.4 Awareness and understanding of the ethical dimensions of health promotion and their application in practice**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
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<td>4</td>
<td>7</td>
<td>4.43</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Awareness and understanding are not measurable. Perhaps use other words to demonstrate the ability to do this.
2. The awareness of the need for ethical guidelines or codes of practice to protect both health promotion practitioners and the communities they work with appears to be growing. The underlying theory, values and principles of ethical practice are complex and worthy of more attention than this one statement provides. A separate code of ethics can provide a greater insight and a tool to quantify what constitutes ethical practice. A code of ethics will strengthen credibility and better align health promotion alongside other health disciplines that are sometimes considered more robust. Recommend that the ethical dimensions of health promotion should be further explored, identified in a separate section and developed into a code of ethics for practice.

**Actions Taken**

Changed to: “Demonstrate knowledge and understanding of the ethical dimensions of health promotion and their application in practice”.

Most countries will not have a code of ethics for health promotion practice, and in the absence of an agreed international code, it may be best to keep this open at this stage.
### Question 98. 10.5 Appreciation of the importance of context for health promotion practice and the socio-ecological model of the settings-based approach

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
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<td>1</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>4.14</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. already explicated in previous competencies
2. Appreciation is not measurable. Perhaps another word to demonstrate the ability to do this
3. Settings-based approach – recommend that the later half of this sentence be deleted and the sentence complete at the word practice.

**Actions Taken**

Changed to: “Demonstrate understanding of the importance of context for practice based on the socio-ecological model of health promotion”.

### Question 99. 10.6 Knowledge of the biological, behavioural and socio-environmental determinants of health and their implications for the development of effective health promotion policies and programmes

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>4.57</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. ... and other determinants ...
2. Knowledge of the biological, behavioural, social and environmental
3. This leaves certain professions/activities out.

**Actions Taken**

Changed to: “Demonstrate knowledge of the social, environmental, behavioural and biological determinants of health and their implications for the development of effective health promotion policies and programmes”.

### Question 100. 10.7 Understanding of the concepts of health inequalities and inequities, their impact on health status and their relevance for health promotion policies and programmes

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>1</td>
<td>6</td>
<td>8</td>
<td>4.63</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Understanding is not measurable. Perhaps another word to demonstrate the ability to do this.
2. This is possibly one of the most important competency statements in the document but its prominence is lost by its position. Recommend that this statement be moved forward to number 10.1 or 10.2 within this section

**Actions Taken**

Changed to: “Demonstrate understanding of the concepts of health inequalities and inequities, their impact on health status and their relevance for health promotion policies and programmes”.

Now moved to 10.3 in revision.
### Question 101.

**10.8 Appreciation of the impact of local, national, regional and international health systems, policies and priorities on health promotion practice**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
<td>1</td>
<td>5</td>
<td>8</td>
<td>4.38</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Not everywhere in Europe is HP a part of a health system
2. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with academic background who work in politics can be considered health promotion professionals.
3. Appreciation is not measurable. Perhaps another word to demonstrate the ability to do this.

**Actions Taken**

- May not be part of the health system but surely will interact with it and therefore requires knowledge of its functions.
- Changed to: “Demonstrate awareness and knowledge of the impact of local, national, regional and international health systems, policies and priorities and their impact on health promotion practice”.

### Question 102.

**10.9 Awareness of, and sensitivity to, social and cultural diversity in all aspects of health promotion practice**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>8</td>
<td>4.5</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Is it knowledge?
2. Same comment as above.

**Actions Taken**

- Changed to: “Demonstrate knowledge of, and sensitivity to, social and cultural diversity in all aspects of health promotion practice”.
**Question 103.** Do you think there are any other competencies that should be included in the core domain Knowledge?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(4) 50%</td>
<td>(4) 50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respondents Suggestions</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Understanding of the basic principles and ability to use the basic Methods of epidemiology and social statistics to be able to analyze the biological, behavioural and socio-environmental determinants of health</td>
<td>1. This point has been covered explicitly in the Evaluation and Research domain.</td>
</tr>
<tr>
<td>2. Awareness of the health situation in your community, organisation, society and internationally ...</td>
<td>2 &amp; 3. ‘Awareness of the health situation in your community, organisation, society and internationally’ Included in 10.8 and 10.9.</td>
</tr>
<tr>
<td>3. Or instead of 101: Be familiar with the national health system and health system. Knowledge competencies - the list does not include much of the knowledge that would be required to demonstrate all the competencies above. In the PHSCF for example, the competencies are known as ‘shows how’ i.e. the practitioner can demonstrate/show that they can do these things. These are all underpinned by knowledge requirements - ‘knows how’. This is an excellent list of core health promotion theory and practice knowledge, but not the depth underpinning the other core areas. Maybe I’m straying into the prof standards area here! Not sure what they mean by laying it out like this. While the definition ‘knowledge competencies’ refers to the ‘ethical Dimensions of health promotion there is no explicit mention of ethics in the Accompanying set. As an alternative, perhaps consider ‘referring to ‘values and principles’ instead of ‘ethical dimensions’. The latter term evokes connotations that go beyond the stated competencies.</td>
<td>5: Point taken but we will await further feedback before deciding to incorporate require knowledge competencies throughout the other domains or keep as a stand alone foundation knowledge domain.</td>
</tr>
<tr>
<td>6: covered in 10.2 “Understanding of the core concepts and principles of health promotion and their application in practice” Also the background document also includes a section on core values and principles underpinning the competency framework. See earlier comment re code of ethics.</td>
<td></td>
</tr>
</tbody>
</table>

**Question 104.** Domains

Are there any domains that you would like to see added to the framework document?

<table>
<thead>
<tr>
<th>(1) 12.5%</th>
<th>(7) 87.5%</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Respondents Suggestions</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What is about technical skills i.e. computer skills, team building skills, peer support skills, presentation skills etc.?</td>
<td>Already included in the competency statements.</td>
</tr>
<tr>
<td>2. Looking through the domains as a set, there are many health promotion approaches which could themselves form domains, and do so in other systems. (Here they are relegated to be part of a domain with a more general title). I am thinking of things like: Community development, facilitation, training, healthy policy development, capacity-building). Many of these terms flow directly from the Ottawa Charter. They are also echoes in other frameworks such as Alan Beattie’s (1991) model, and our own HSE draft Framework for Health Promotion</td>
<td>Agree but separating out all of these sub-domains could become quite unwieldy.</td>
</tr>
<tr>
<td>3. In general, the domain groupings and names seem very logical and easy to follow.</td>
<td></td>
</tr>
</tbody>
</table>
**Question 105. Domains**

Are there any domains that you would like to see removed from the framework document?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) 25%</td>
<td>(5) 75%</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. maybe I would combine or connect some domains like: assessment, evaluation, research; advocacy, communication; leadership, partnership, (enabling change)

2. Assessment and evaluation could be combined together. The framework could be simpler in all (e.g. something like 20-50 definitions altogether with the overlap removed).

3. You could make a case for combining ‘Assessment’ and ‘Planning’ into a single category as the former as a critical step/skill set for the latter.

4. In the list of the 10 domains, on pages 5 & 6, the title Knowledge of the theory, Research and ethical dimensions of health promotion, stands out as being more comprehensive than any of the others which are only one or two words. Recommend that the format of domain names be standardised.

**Actions Taken**

These domains could be clustered but will await further feedback on this.

---

**Question 106. All Competencies**

Overall, I would rate the competency framework as:

<table>
<thead>
<tr>
<th>Very Poor</th>
<th>Poor</th>
<th>Uncertain</th>
<th>Good</th>
<th>Very Good</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1</td>
<td>4</td>
<td>4</td>
<td>9</td>
<td>4.33</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. very comprehensive

2. Competencies are very ambitious and very demanding on their evaluation or testing on individuals entering into health promotion, however if I see ideal HP practitioner profile, they fit perfectly.

**Actions Taken**

These domains could be clustered but will await further feedback on this.
### Question 107.

**All competencies**

**The framework adequately reflects current health promotion practice**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>3</td>
<td>3</td>
<td>2</td>
<td>9</td>
<td>3.67</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. It depends on how one interprets this. It reflects how health promotion practice is currently being described in theory.

2. The framework adequately reflects the desired but not necessarily current health promotion practice.

3. According to my experience, not. Current health promotion is based more on professional knowledge on specific topics or specific population and not on abilities and skills.

**Actions Taken**

- This type of engagement is integral to health promotion practice.

### Question 108.

**All Competencies**

**This framework will be useful in developing workforce capacity for health promotion in Europe**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>3</td>
<td>2</td>
<td>4</td>
<td>7</td>
<td>4.22</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. This strongly indicates certain view of health promotion competencies; e.g. it looks like only people with an academic background who work in politics are considered health promotion professionals.

**Actions Taken**

- This type of engagement is integral to health promotion practice.

### Question 109.

**All Competencies**

**This framework will assist in planning health promotion workforce capacity for the future**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
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<td>2</td>
<td>2</td>
<td>4</td>
<td>9</td>
<td>4.00</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Not the framework itself but together with accreditation system.

**Actions Taken**

- Not the framework itself but together with accreditation system.
### Question 110.
**All Competencies**

**This framework adequately reflects the evidence base for good practice in health promotion**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>3</td>
<td>2</td>
<td>9</td>
<td>3.56</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

1. Much of this we must take on faith, as the evidence is very limited, with methodological competencies in assessment (in particular epidemiology and social statistics)

2. I would go to "Strongly Agree"

3. I do not know if I know enough to answer

**Actions Taken**

This type of engagement is integral to health promotion practice.

### Question 111.
**All Competencies**

**This framework adequately reflects the ethical dimensions of health promotion and their application in practice**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>9</td>
<td>4.33</td>
</tr>
</tbody>
</table>

**Respondents Suggestions**

Please add to glossary a definition of HP ethics

**Actions Taken**

The background document already includes a section on core values and principles underpinning the competency framework and endorses the ethical principles of empowerment, equity, participatory etc.
**Question 112.** If you have any suggestions on how to improve the framework as a whole or specific competencies please give detailed feedback here.

<table>
<thead>
<tr>
<th>Respondents Suggestions</th>
<th>Actions Taken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> In the last months I tried to overlap the domains from Galway consensus with the scheme of a community action plan. This helped me to define better the meaning and importance of the competencies. Maybe we could use a similar approach.</td>
<td>1. If the respondent wishes to send their work to us we can certainly explore this.</td>
</tr>
<tr>
<td><strong>2.</strong> I suggest to keep is more simple and be as much as possible clear and concrete in description of each of competency. It facilitates its use in practice otherwise it could stay to be an academic exercise</td>
<td>2. Further feedback from Delphi round 1 may assist in simplifying this document further</td>
</tr>
<tr>
<td><strong>3.</strong> I have posted them separately. Within the time frame it is not possible to go through this in more detail. In general the framework is very comprehensive and it could be simplified to work better in different health promotion contexts. If core competencies are defined as they are defined here, most people currently classified as health promotion professionals do not qualify.</td>
<td>3. Given the high levels of mean ratings not sure that all agree with this comment but will await further feedback.</td>
</tr>
<tr>
<td><strong>4.</strong> I understand the appeal of a system which focuses on entry-level practitioners but I also feel we need to recognise skills in relation to management and commissioning functions in Health Promotion.</td>
<td>4. Not all countries have commissioning functions for health promotion practitioners or in their health systems.</td>
</tr>
<tr>
<td><strong>5.</strong> We need a strong case for arguing that domains 1-9 are performed differently in Health Promotion rather than just linked to a different knowledge base</td>
<td>5. Workpackage 4’s literature review.</td>
</tr>
<tr>
<td><strong>6.</strong> There are examples dotted around related to ‘health equities’ e.g. 7.10 Without rationale. Does work on health equity require different competencies?</td>
<td>6. Health equity is fundamental to the principles of health promotion in the Ottawa Charter.</td>
</tr>
<tr>
<td><strong>7.</strong> I like the content of the ‘enabling change’ category, but it is written at a More macro (Ottawa-Charter) level than the other categories. You may want To look at re-structuring the categories in a way that places ‘enabling change’ As an overarching domain (which it is= and the other categories as more Skill-specific sub domains.</td>
<td></td>
</tr>
<tr>
<td><strong>8.</strong> Health promotion is evolving at an ever increasing pace and CompHP will Need to keep ahead of changing trends. Shifting the focus from ‘settings’ and ‘settings-based approaches’ to rights based approaches that focus on equity will better reflect the commendation from the 2009 report ‘Closing the gap in a Generation’ the WHO Commission of Social Determinants of Health. ‘Settings’ or ‘settings-based approaches appears several times in the document. The WHO definition of a setting has a strong implication of an environment which is built or has physical boundaries. “A setting is where people actively use and shape the environments; thus it is also where people create to solve problems relating to health. Settings can normally be identified as having physical boundaries, a range of people with defined roles, and an organisational structure. Examples of setting include schools, worksites, hospitals, villages and cities.’<a href="http://www.who.int/healthy-settings/about/en/">http://www.who.int/healthy-settings/about/en/</a> Recommend that settings be replaced by a focus on achieving social justice And equity through addressing the social, structural and ecological Determinants of health.</td>
<td></td>
</tr>
<tr>
<td><strong>9.</strong> Uses of Core Comps – the NZ experience shows there can be uncertainty About how to implement the competencies. – Recommend that the working Group consider developing a pool of models or sample templates eg a Competency based job description, or workforce development needs Assessment and others as appendices to the competency document</td>
<td></td>
</tr>
</tbody>
</table>
Table 7: Results from Delphi Round 1

**Question 1. Do you agree that the introduction and background document is clearly presented?**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3% (4)</td>
<td>1.1% (1)</td>
<td>4.3% (4)</td>
<td>60.2% (56)</td>
<td>30.1% (28)</td>
<td>93</td>
</tr>
</tbody>
</table>

**Comments**

1. The criteria for evaluation of the conditions and achievements of the core competencies in the variety of settings are needed, in order for them, as well as for the improvement to be measurable … more focus on public involvement would be needed.
2. The field of health promotion is complex! The introduction and background are “100% Ottawa charter” (even if there is references to other texts p 2) and I ask myself if it could be relevant to introduce some ideas from more recent work.
3. The descriptions of competencies could be more focussed, could differentiate more precisely. The description of the competencies include both, competencies and visions of health promotion - visions should be expressed in the introduction and not in each description of the competencies (all competencies should contribute to reach the visions of health promotion).
4. I miss the in the literature the quality standards used in the German speaking countries (Germany, Austria, Switzerland) There are important quality standards introduced. Unclear is the role of accreditation.
5. Yes, it is comprehensive and clear, summarizing the present international shared state of art of health promotion.
6. I would expect to that the concept of framework for competency-based standards and accreditation should be more specifically defined. Also component of accreditation should be addressed as it seems only the core competency is analyzed and presented.
7. Would like to see little more information about literature review.
8. Content overview would be fine. Who are addressees of accreditation system?
9. The problem to me is the definition of “health promotion practitioner”. As presented a researcher at University doing research on environment is the same practitioner as a city planner who does housing planning. Can we indeed use the same competence framework for both these persons?
10. I think the document is a clear “state of the art” about core competences for health promotion.
11. As HP activities are described as promoting health ad reducing inequities it seems reasonable to think about HP definition as ’process of… control over the (rest not available).
12. A bit too long. Can be more pin pointed. Lack explanation of health equity under core values.

**Question 2. In relation to the introduction and background document, do you think it is?**

<table>
<thead>
<tr>
<th>Too Long</th>
<th>Too Short</th>
<th>About Right</th>
<th>Other</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>7.5% (7)</td>
<td>2.2% (2)</td>
<td>83.9% (78)</td>
<td>6.5% (6)</td>
<td>93</td>
</tr>
</tbody>
</table>

**Comments**

1. Introduction is alright, description of single competencies is not focussed enough
2. A bit too long and detailed, finale document needs to be user friendly as people with different background will read and use it
3. Length is appropriate to provide background information and detail on each of the 10 competencies
Question 3. Do you agree with the content of the Introduction and Background of the Framework document?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1% (1)</td>
<td>2.1% (2)</td>
<td>7.4% (7)</td>
<td>58.5% (55)</td>
<td>30.9% (29)</td>
<td>94</td>
</tr>
</tbody>
</table>

Comments

1. Should highlight these core competencies are for graduate or post graduate practitioners (consultants/specialists?) and could be not relevant for front line providers carrying out the day to day tasks in health promotion and working directly with individuals or groups.
2. In some respect Anglo thinking is predominant.
3. P5 - not sure safe to claim ALL the key elements refer to levels of expertise may be confusing. No levels are stated here and indeed some of the expectations may be v high. This is an issue to be addressed in the standards and assessment systems, so perhaps ref these steps here rather than this vague statement.
4. I’m not sure about need and relevance of accreditation system because circumstances and structures in health and social systems are different.
5. I think that one of the principles of health promotion should be the population approach. Such a item might be included among the points at the bottom of page 2.
6. The practitioner part should be more clear.
7. The intro should further explore the issue of accreditation. Accreditation is an expected outcome of the overall project but is not considered in this document.
8. I understand it, but I am afraid it will be very abstract and compromised. It is very difficult to come to a set of competences at national level; there are so many different jobs/competence need. I think it will be an abstract, overall set of competences; and not really surprising. At the work floor we need something more concrete and specific.
9. Especially with reducing inequities
Question 4. Domain 1. Enabling Change

Enabling Change and empowering individuals and communities to improve their health.
Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1% (1)</td>
<td>1.1% (1)</td>
<td>2.2% (2)</td>
<td>38.2% (34)</td>
<td>57.3% (51)</td>
<td>4.49</td>
<td>89</td>
</tr>
</tbody>
</table>

Comments

1. I would say societies, communities and individuals ... And on how to achieve it - the order of priorities, where to start is also not the same for each setting /country/.
2. This comment applies to the wide range of competences in general: I well can agree that this range of competences is needed to achieve results in health promotion. On the other hand it is difficult to expect that this range of competences can be found usually (and well balanced) in individual persons. But - HP is usually a task to be shared among many individuals (and organisations).
3. It should be clear that Health Promotion (HP) has included the concept of Capacity-Building(CB).
4. Yes, but specific methods how one can be a change agent/enable change should be cited more precisely, e.g. organisational development, change management, process management, and advocacy. Each single method should be one competency.
5. I think there is major problem with this one. Of course enabling change is core, but this is an overarching goal. The competencies stated encompass the whole of health promotion individual aspects. Its far too wide. In contrast it doesn’t do at all is specify the types of competency required to manage organisational, individual change - there is a body of knowledge & skills about change management that should be here, not a restating of the Ottawa Charter!
6. Health Promotion actually means to implement a process of social change or rather to set up a social movement for societal change.
7. I agree that change should be considered among the competencies, but, as it is formulated, it refers to an attitude. No skills are included. Therefore it might seem generic.
8. “Action for choice”
9. Assuming that there is a clear concept of change and empowerment.
10. If we do not ensure this happens then what is the point of health promotion.
11. The term “health” here might not cover it completely as it might be better to talk about quality of life or similar terms! But at the same time I understand what is meant. HP is wider than focusing health issues.
12. It is a very complex subject to explain in so short space.
13. Competencies in this domain are important, but have to meet with community readiness. Therefore it seems crucial to me having the competence to assess community readiness.
14. This domain clearly addresses each of the five action areas in the Ottawa Charter.
15. Of course, this is our core business.
16. Enabling change domain seems to be function of leadership and partnership - those three are strongly interrelated; when enable and advocate is considered.
Question 5. Competency 1.1
Enable individuals and communities to improve their health and reduce health inequities through undertaking a variety of health promotion activities including community development and empowerment strategies, advocacy and lobbying, organisational and environmental strategies, mass media strategies and health education

Do you agree this competency is core to health promotion practice?

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<tr>
<th>Strongly Disagree</th>
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Comments
1. I think it is too demanding for entry level health promotion practitioners.
2. Variety of health promotion activities should be specified exactly or left open.
3. Empowering community should start with a healthy public policy and supportive environments as preconditions, while investing in individual health promotion activities, not a vice verse.
4. Again - I do for example not expect that each HP expert is also an expert in behavioural change - a professional education in behaviour modification (based on psychological evidence) usually takes years. Quite different skills again determine the success in community development etc.
5. However the above described activities are quite different i.e advocacy (more developed at the national level and for specialists) and health education (core competency for field workers).
6. Provide evidence for the added-value of HP and CB to preventive actions.
7. Too unspecific/general, mixture of several general competencies. But advocacy/lobbying competencies are very important, also Public Relation competencies.
8. Yes but is a goal not a competence - and is covered elsewhere.
9. Health is a matter of social justice!
10. I would ask what the "variety of health promotion activities" is. Using "reverse logic" lobbying for a new park by a group of environmentalists is enabling change and fits this competence and definition. So, is an environmental lobby group a health promotion practitioner group?
11. A clear distinction between domains and competencies should be made.
12. I am not certain about advocacy and lobbying being core competencies.
13. This is not a competency; these are many competencies!
14. Item 1.1 covers (equals) 1.5. It should be taken as explanation to overall domain.
Question 6. Competency 1.2
Contribute to building healthy public policy across all sectors and levels to ensure that health, economic and social policies lead to improved health and reduced health inequities
Do you agree this competency is core to health promotion practice?

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Comments
1. Not all practitioners have an access to policy matters. Flexibility is necessary when applying these requirements.
2. Not sure the building of policies corresponds to a graduate level.
3. Change and building healthy public policy should be understood as an essential element of CB.
4. Vision + competency is mixed (visions should be mentioned in the introduction).
5. Yes but is a goal not a competence - and is covered elsewhere.
6. There are many structural drivers which affect the living conditions of people and therefore their health too.
7. I do agree but I would add more policies (education, transport, agriculture, ...).
8. We do need to make sure that people understand the Political dimensions here, some Government policies will go ahead even when there may be the potential for adverse effects so Political Awareness is key and often missing.
9. Some societies are not sensible to our endeavour.
10. Not all practitioners might readily identify this aspect of their work. It might be useful here to clarify the ways in which this can be achieved i.e to make the links between practice, evidence and policy.
11. Of course.
12. Key factor within Ottawa framework; nowadays it can be considered in international dimension too.

Question 7. Competency 1.3
Contribute to the creation of supportive environments to improve health and reduce health inequities using approaches such as the settings-based approach
Do you agree this competency is core to health promotion practice?

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Comments
1. To produce organizational changes and create better environments where people live, work, study is basic for better conditions of life and offers sustainability.
2. Using setting-based approach = important but not very specific.
3. Yes but is a goal not a competence - and is covered elsewhere However ref to settings-base approach - there could be a competency related to K&S here, but not in this section probably implementation.
4. The crucial question is: "How much control people have over their live" (Michael Marmot) or "the freedom to be and to do" (Amartya Sen) are fundamental for putting the health promotion approach in practice. The setting-based approach is in this case predestined to strengthen people's autonomy to act and to create their own social and physical environment. Along with this they will become politicized in a positive sense that they can experience that they are not powerless. This creates empowered people and leads to what is called empowerment.
5. More-less the same as 1.1, un-necessary duplication.
6. Forces against because lack of knowledge by professionals from different sectors, important is how newcomers involve in the practice beside professional knowledge.
**Question 8. Competency 1.4**

Strengthen community action by facilitating community participation and ownership through community development processes, and building capacity within communities for improving health based on mutual trust and respect.

Do you agree this competency is core to health promotion practice?

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**Comments**

1. It is not very clear how it applies in practice, for example in a poor, segregated, marginalized community... where building participation on mutual trust and respect requires long term investment in the processes of change... which is often not highly appreciated by the "both sides"/political/programs and community.
2. It seems there is some confusion about CD processes, capacity and trust and respect; they are different things although linked.
3. But: vision + competency is mixed (visions should be mentioned in the introduction) knowledge and experience in community participation methods = very important
4. Yes but is part of implementation and other areas. K&S about community development are core to hp.
5. Again: Social movements are strong indicators for change but they have to focus on improving the living condition and quality of life.
6. Lack of knowledge in organizations, some NGO have the leading role and are advanced, that lead to later action sometimes the change of generations needs more time to provide new visions.
7. It depends, not necessary. It depends on the questions and needs from the community. Probably something else is needed or asked for. This is one possibility; not always a need. Is it a core competency then?
8. Might fit better under leadership.
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**Comments**

1. I think that in many (individual) cases skills (also using sophisticated methods of analysis and intervention) are needed to understand undesired behaviour and achieve changes. Sometimes concepts developed in the field of HP appear too simplistic.
2. Personal change and ACTION to support and provide real opportunities.
3. Vision + competency is mixed, competencies in health education are very important.
4. Yes again part of implementation.
5. Freedom with its daughters education and welfare are fundamental to health as the well-known German pathologist' pointed out.
6. Good life!
7. Enable individuals to make healthy choices through health education is valuable only if the individual have chosen to take part of health education themselves. Paternalistic health education has nothing to do with health promotion!
8. Perhaps semantics but is it healthy or healthier choices? After all it depends on the circumstances a person or community finds itself as to the degree to which they can exercise that choice, they may only want healthy food but it may be limited so it may be healthier rather than healthy.
9. It could be argued that the HP practitioner’s role might best be applied to building the capacity of others to develop personal skills in individuals. The number of HP practitioners required to have a population impact through personal skills development would be enormous, and unrealistic. Better outcomes might be achieved through building capacity of other health professionals, and those working in the community and education sector to support individual skill development.
10. It’s suitable that home, kindergarten, leisure time, process of education at all level for professionals, consumers, lay are the partners from the beginning of changing process, we are face with human rights and rights to health in some countries, continuous education and training for different sectors, profession, lay and level.
11. That support action competency within community.
12. I disagree according to the social determinants of health. There are many other aspects that have greater impact on changes than health education.
13. Depends on if you work in the health sector. Then this works
Question 10. Competency 1.6
Contribute to the reorientation of the health service towards health promotion and reducing health inequities through the provision of information, expertise, collaboration and partnership
Do you agree this competency is core to health promotion practice?

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Comments

1. Again health promotion practitioners do exist beyond health systems, e.g. teachers, community leaders, etc. Their contribution to reorient health services is limited.
2. Okay with the idea but not with the field (health service). Many professionals in HP don’t work in health sector but in social or educational sector (social workers, teachers). They have to promote the reorientation of their own context of activities towards health promotion.
3. And political changes: employment, education, specific approaches; otherwise it is good intentions.
4. Building up + maintaining partnerships = very (visions should be mentioned in the introduction).
5. It is too ideal and not taking into account cultural environments.
6. Not just the health service - this really is just restating Ottawa Charter
7. After more than twenty years of health promotion movement (since Ottawa 1986), theory and practice I am a bit sceptical whether the strategy to re-orientate the health service as an important element to help health promotion on the road to success could be more as just wasted time. The well meant WHO 'Healthy Cities' project was and is in this context not very convincing at least not in Germany.
8. The primary health sector should focuses first and foremost on primary- and secondary prevention. The secondary health sector should also focus on primary and tertiary prevention with focus on improving individually skills.
9. Again this is one where the political dimensions with a small p come into play. Practitioners need to have a strong understanding of the culture and organisational objectives of each section of the health system they work with and to be sensitive to that and adapt approaches accordingly, a bit of humility goes a long way.
10. Today this has a priority in the time of crisis, get the right information at the time is the crucial for reach this change, PHC is the needed as a frame for HC Services.
11. In our experience it seems the most difficult action defined by Ottawa Charter.
12. Health services work on their own plans with curative goals and change to health promotion is not obligatory for them.
13. Of course.
14. Depends if you work in the health service sector. Then this works.
Question 11. Do you think there are any other competencies that should be included in the core domain Enabling Change?

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Comments

1. Research - should be added.
2. Competence in supporting the change /at all levels/, by recognizing the value of the process, rather than the immediate outcome.
3. Important that people who initiate change also subject themselves to those intended changes. HP must not become an ascetic unrealistic issue and therefore the proof by doing oneself is important. But - not to be misunderstood - this does not mean that for example that only absolutely proven missionaries (with proper eating habits, regular exercise, absence of any addiction etc.) have HP competence!
4. These are the classical Ottawa based lines, all of them are valid. However, understanding the problems/inspiring changes to focus on the health aspects of globalization/ security, climate change, trade, etc./ should be considered.
5. To create systems that assure participation in decision-making and policy production.
6. Organisational development, change management, process management.
7. Competencies about change management, being an agent of change etc at level of individual, community, organisation, partnership....
8. Critical Thinking! This is to me more important as the overestimated evidence debate. Evidence is relevant if it demonstrates that programmes, measures, projects, and activities working as intended not just for scientific reasons (UDE - Utility Driven Evidence).
9. Using various training methods and technique for developing personal skills.
10. There are sometimes prejudices or misconceptions that may represent obstacles to changing and empowering communities. I would indicate those regarding obesity, seen as a disease or guilt, a misconception very common among the politicians. May be the individuation of prejudices and other cultural obstacles, a competence, in this domain?
11. Guide and support organisations to plan, implement and evaluate programs to promote health and prevent disease through education, behaviour change, community organization, and advocacy.
12. Core competencies concerning change management.
13. Focus on the issue of human relations (relations between individuals or groups) could be more strengthened, to contribute to moving from culture of violence/mistrust to culture of mutual trust and respect.
14. More on health in other policies and the social determinants of health.
15. Competencies related to implementing certified interventions should also be included in the domain of enabling change.
16. When we talk about personal skills in general it seems we are talking about the same but if we specify there will be a complete antagonistic view. The same happens with the provision of information.
17. The competencies involved in community development require further exploration. I’m not sure if this might require it’s own domain. I acknowledge that many of the competencies involved are within other domains, but as this is such a core element of HP practice it doesn’t seem sufficient to see it only mentioned in passing in this section.
18. Learning process of communications -practical approach, how to understand each other, listen and respect the partners rights too team work is the basis for understanding and enabling Change towards health determinants, more strategic knowledge in health suggested goals.
19. Delivering knowledge and teach skills on important factors strengthening the health during the school based education.
20. Competence to assess community readiness is crucial because without it no change will be enabled.
21. To enable change also an active role of the national, regional and local policy change is necessary as also an active involvement of expert structure/institution is needed ( like Public Health Institutes, School of Public Health, University...)
22. The competence to listen and analyse the process that’s going on in the community, school or whatever; and join the process through interventions with de HP goals; you have to be creative and open minded.
23. Effectiveness of health promotion (how to measure it - how to communicate it, etc.
24. Possibly the recognition of the social constraints and difficulties should be part of this enabling change process.
25. Try and narrow it down to fewer aspects of Enabling Change

**Question 12. Domain 2 Leadership**
Contribute to the provision of strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion, supporting health promotion programmes and building capacity

Do you agree this domain is core to health promotion practice?

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<th>Strongly Disagree</th>
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Comments
1. Okay for graduate or post graduate specialist but not to the same extend for front line providers.
2. Interesting to see how this applies at different levels of workforce?
3. See my comments to the previous point 'Enabling Change'. For this, indeed, leadership is needed. Without leadership no societal change.
4. Is it possible to clarify that leadership, in this context, do not refer only to the "personal" leadership?
5. Same as the previous package "Enabling change"
6. Democratic strategic guidelines for participation and development of public health policy.
7. It is necessary, otherwise we can stop.

**Question 13. Competency 2.1**
Demonstrate democratic and empowerment leadership skills reflecting health promotion principles

Do you agree this competency is core to health promotion practice?

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Comments
1. Stressing provision of human' and children' rights while promoting health.
2. Please, explain better in the document what "demonstrate" would mean.
3. I think that this is not a competency, this is an attitude.
4. What do democratic and empowerment leadership skills mean.
5. This is very clear: Paternalism, Scientism and Expertism do not work anymore in a global society.
6. Need to ensure that people reading this are clear as to what this means. We promote a 'distributed' leadership model in developing health promotion/improvement skills and competencies
7. Democratic deficit is traditionally present; more leadership education at different level would help.
8. It depends on the local situation; sometimes an other leadership skill is needed; an explicit and smart leader is necessary.
Question 14. Competency 2.2
Contribute to the development of a vision and strategic direction for health promotion policies and programmes
Do you agree this competency is core to health promotion practice?

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Comments
1. A vision and strategic direction are relevant for advanced practitioners (managers/supervisors).
2. This is no competency, this is a target of health promotion practitioners.
3. Without leadership it is hard to draw up a vision and to gain a strategic direction.
4. I think this is very important yet probably unrealistic for everyone to be able to do so. As a profession we need to do this but maybe a lot to expect of every practitioner vision and philosophy of leaders are important to bring together all partners.
5. I think that is a senior-level competence.
6. Almost the same as explanation to overall domain and item 2.4.
7. 2.2, 2.5 and 2.7 are similar. Can you narrow them down?

Question 15. Competency 2.3
Work to influence one’s own and other organisations and key stakeholders to promote health and address health inequities
Do you agree this competency is core to health promotion practice?

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Comments
1. Is it a competency?
2. Instead of influence it could be clear to raise awareness, interest, motivation and capacity for...
3. Not very specific - motivation or competency?
4. This demands a lot of tact and political acumen.
5. Important salutogenetic point of view.
6. This is lobbying and advocacy, so included in "Enabling change" part.
7. Once again I would like to see a clear linkage to building the 'Political' awareness element which actually cuts across all of the areas and is one certainly at times here in the UK is sadly lacking and often leads to negative outcomes.
8. Innovative knowledge, changing experiences and practice promote and contribute to promote HP and overcome health inequities under given conditions.
9. Key stakeholders linked with community ownership.
10. It seems risky as one can perceive that has a 'moral licence' to pub pressure on somebody
Question 16. Competency 2.4
Demonstrate leadership in facilitating change through utilising interpersonal skills (negotiation, team work, motivation, conflict resolution, decision making, facilitation and problem solving skills) to promote health and reduce health inequities
Do you agree this competency is core to health promotion practice?

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Comments
1. 2.3 & 2.4 should merge in one competence - since, only by successfully facilitating the change..., the others /organizations, stakeholders etc./ become influenced and motivated ... - I would not call all these skills interpersonal only.
2. It sounds more like conducting a good team work instead of addressing inequities.
3. Interpersonal skills are very important.
4. This relates back to comments above in enabling change ie these are change management skills.
5. Social intelligence is more important than expert knowledge.
6. What if someone doesn't have strong leadership skills - a follower rather than a leader?
7. Same as 2.1
8. It is important but mainly effective on individual basis. For health promotion practice as strategic approach more systematic and legislative based approach is needed.
9. This is the definition of leadership; it has nothing to do with PH specially.
10. See 2.2

Question 17. Competency 2.5
Build and maintain capacity in individuals, teams, groups and communities to support the development and implementation of sustainable health promotion policies and programmes
Do you agree this competency is core to health promotion practice?

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Comments
1. Add research.
2. This competence should merge with the first one - clarifying what democratic and empowerment leadership skills are actually about.
3. Strongly agree that this capacity is a must as an attitude. However, this also has to do with skills which sometimes are not so well developed - and I would not exclude those whose skills are not perfect.
4. Not clear how.
5. Not very specific (capacity building comprehends many different competencies and methods).
6. This is very vague and overarching - if it is about capacity-building then it is more clear but probably not in leadership.
7. This is to me one core element that should be part of all education and skills-training programme in the public health and health promotion area.
8. I feel "contribute to ...." would be more realistic formulation.
9. See 1.6
**Question 18. Competency 2.6**

**Mobilise and manage resources for effective and efficient health promotion programmes and policies**

Do you agree this competency is core to health promotion practice?

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**Comments**

1. Strong focus on EBPH movement should be mentioned.
2. For advanced practitioners.
3. And to enable the organization to do so not only the leader.
4. Yes, please, do not forget the managerial skills. They are often not given or very insufficient with health promoters.
5. Mobilise and adapt being aware of contextual limitations (example, political limitations).
6. Of course.

**Question 19. Competency 2.7**

**Contribute to the development and implementation of ethical and evidence-based policies, procedures, guidelines and protocols for health promotion**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
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**Comments**

1. Ethical is not always clear, by saying so, does it mean human rights based?
2. Ethical-based and evidence-based are two different things. Is it a pertinent to put them together?
3. For advanced practitioners.
4. It has to be all the organization.
5. What is the competency? (is it a task but different competencies may contribute to it) (research in databases for evidence-based work, quality management knowledge).
6. I think this is particularly an issue for researchers and action researchers in the field.
7. There has been an increase in the term ‘evidence informed’ policy/decision making rather than evidence based here in Scotland but not sure if this is being used beyond UK. It is an important distinction as it reflects discussions across the EU and WHO on accessing wider intelligence systems and the evidence they have.
8. Only if that's your mission (to develop); it depends on your job/situation. It is not definitely a competency for a leader; can be for a worker.
### Question 20. Competency 2.8

**Synthesise new knowledge and processes into the development of health promotion policies and practice to improve health and reduce health inequities**

Do you agree this competency is core to health promotion practice?

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**Comments**

1. I would say - synthesize new knowledge and processes within ongoing conditions into development.
2. A role on HSR methodologies ought to be provided.
3. For advanced practitioners.
4. With the collaboration of the partners. They have to be active. It cannot, should not be centralised in one person.
5. Vision (to improve health and reduce health inequalities) should be included in the introduction. Is this a leadership competency?
6. DK what this means, and how you would assess competence?
7. Probably one of the most important tasks in order to continue the process of generating evidence and demonstrate the evidence of the health promotion approach.
8. Again, maybe a lot to expect of each practitioner.
9. I think this is too demanding for HP practitioners, it needs an agency or close links to academia.
10. This is not matter of leadership.
11. Appears to be overlap between 2.7 and 2.8.
12. There is enough knowledge and processes known that should be implemented. New one are necessary for the future, but now the existing one should be implemented at first and effect fully.
13. See 2.7
14. It seems more relevant to knowledge domain.

### Question 21. Competency 2.9

**Engage in reflective practice and take action to identify and meet learning and development needs at individual and organisational levels**

Do you agree this competency is core to health promotion practice?

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**Comments**

1. I think this is not a competence, but rather the step that should be built in the competence 2.5.
2. Too formal.
3. Catalyst.
4. Task = engage in reflective practice competency = be able use evaluation methods, be able to reflect processes, be able to identify developmental needs.
6. Societies level too.
7. See 2.4
**Question 22.**

Do you think there are any other competencies that should be included in the core domain Leadership?

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**Comments**

1. There should be a text about research and developing indicators for efficient programmes. More needed about how you know we are meeting the needs of the groups we are working with.
2. Some of them are too close and related and could merge.
3. I think the willingness to listen to others, the commitment to team-work is included under heading 21 - 2.9 engage in reflective practice.
4. Be careful when addressing this. There are no perfect leaders, certain prioritization is needed among competencies, for me the ability of strategic thinking, team building and resource management are the most important ones.
5. Less preponderant: give space for others without loosing the main vision and control of the process according to it.
6. Respect and listen to the people that one can understand their needs properly and guide them in order to find their own way of healthy living and a good life.
7. How to interact with local and regional decision makers to convince them about importance of benefits of health promotion.
8. I suggest the inclusion of “networking” as a competence in this domain. It is rare that you have enough resources for your hp programme. Networking is part of this domain. It might be also in the partnership domain, but not how it is written now.
9. Apply knowledge, use interpersonal skills to work effectively cross-culturally in Europe, worldwide by understanding, respecting cultural differences & similarities within & between culture.
10. May be it is to comprehensive, focus should be more on aligning HP strategy with the overall strategy in the community/setting.
11. Provide facilitation and leadership to health in all policies approaches. The same applies for SDH and global health issues.
12. Some of the competencies mentioned here refer to other domains. A clear definition of the domains and their relation/boundaries to each other is necessary. Also their relative importance should be addressed. This need to be plotted in a figure.
13. Positive, general and health policy in building health system in given conditions Leaders must be able to cover leadership’s needs together with the other team and bodies in HP process and local community ... critical approach to the existing HS.
14. There should be a legislative basis for a minimum criteria or a level for adopting health promotion leadership and strategy on local, regional and national level to avoid the dependency on local conditions and to avoid inequity between different local communities.
15. It is not specific for HP what a good leader is.
16. Health promoter as a teacher - it can be included in leadership or communication - maybe as a separate domain.
17. Facilitating the transformation of research evidence into policy and practice.
18. Try and narrow it down. It is a huge challenge to both act on an individual level and organisational level in the implementation phase of HP whether it is in leadership or implementation. Who works like this in reality?
19. Knowledge of the public health system, main stakeholders, actors etc.
### Question 23. Assessment Domain
**Conducting assessment of needs and assets in settings and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental, organisational and political determinants that promote or compromise health**

Do you agree this domain is core to health promotion practice?

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<tr>
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**Comments**

1. Here you have the determinants.
2. I agree but it is the way how to do it what is crucial. In my opinion this works only adequate if you do it with the people and not for them. Thus, it is a matter of applying the right methods.
3. It is certainly a core competence in health promotion to be able to identify determinants that promote health. Am less sure that the ability to identify determinants that leads to ill-health is a core competence of a health promotion practitioner. It might be a core competence of public health. We need more knowledge of salutogenic determinants!
4. This has to do with research. Research as such should be a domain for professionals. This is a combined domain of Assessment and Evaluation.
5. ADD 'ECONOMIC' TO DETERMINANTS LIST.
6. I suggest to make a cluster of 3.1, 3.4, 3.5, 3.7 (answering question 'what') and 3.2,3.3, 3.6 (question 'how')

### Question 24. Competency 3.1
**Collect, review and critically appraise relevant data, information and literature for health promotion policies and programmes from primary and secondary sources using a variety of methods including social sciences and epidemiological methods**

Do you agree this competency is core to health promotion practice?

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**Comments**

1. Could be divided into different competencies: Research and appraise relevant data, information.
2. Knowledge about using different assessment tools and social sciences and epidemiological methods.
3. But this is a huge sweep of K&S again. What levels of expertise would be required in all these areas. May be better to word more at a level of know about know where to get info/support and how to use in hp practice. At the moment this would cover two whole core areas of public health!
4. For me the main focus should be on action research and participatory approaches.
5. Assuming training courses equip practitioners with these skills.
6. Not only evidence based.
7. Too demanding. Requires research (review) expertise.
8. See comment in number 19.2.7.
9. This is part of the suggested research domain
10. Some data from different sectors. Services luck of competent professionals.
**Question 25. Competency 3.2**  
Identify and involve community members and other stakeholders in health promotion assessment processes

Do you agree this competency is core to health promotion practice?

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**Comments**

1. Roles, forms and methods of such an aetherogeneous participation should be better defined.
2. Participation methods/processes.
3. Practical problems.
4. I don’t see the word participation anywhere, this is an overarching community participation principle, which is repeated, correctly in other sections. I don’t think this reflects the competencies underlying it. Also ‘identify’, ie HPP is in control doesn’t sound very participatory!
5. Participation is crucial to all health promotion activities.
6. Important to involve stakeholders and community members in prioritising focus areas based on relevant data from assessments.
7. This kind of community base participatory research is one core competence to long term sustainable health promotion interventions.
8. This is more process oriented in order to enable assessment.
9. We wish to organize them education for better working for the same goals and HP assessment process, opinion of lay people, verifying important perception oh HP.
10. Involving community members is essential.
11. It depends; probably most of the time.

**Question 26. Competency 3.3**  
Identify, adapt and apply culturally relevant and appropriate health promotion assessment approaches for people from diverse cultural, socioeconomic and educational backgrounds and of all ages, genders, health status, abilities and sexual orientation

Do you agree this competency is core to health promotion practice?

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<tr>
<th>Strongly Disagree</th>
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<th>Agree</th>
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**Comments**

1. But not everybody must be an expert for each branch of diversification.
2. This should be done without increasing stigmatisation between groups and also within the entire population.
3. It should be clear the principle but not all those target-groups. It seems that is going to address to all of them at the same time.
4. Diversity management knowledge and skills, knowledge about gender sensible health promotion.
5. Diversity Management.
6. Could be difficult to comprehend.
7. Hard to understand what is meant.
8. Health promotion must have a local approach, that means that health promotion design must base its roots and be developed on local needs.
9. More research like.
10. Religion.
11. Also essential.
### Question 27. Competency 3.4

**Identify existing assets and resources at all levels in organisations and communities which can support action on health promotion to improve health and reduce health inequities**

*Do you agree this competency is core to health promotion practice?*

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</table>

**Comments**

1. Competencies 3.3 and 3.4 could go under the same competence.
2. Not very specific competency (rather task).
3. All levels may be a little ambitious!
4. This is also true for individually existing assets and resources that people often not aware of it.
5. All resource related tasks are to the side of the contents tasks.
6. Political leaders, mayors, professional from all sectors have great influence, therefore they need to get basic education and information which support personal view, reflected in decision for HP understanding and activities at different levels.
7. What do you mean by ALL levels?

### Question 28. Competency 3.5

**Identify the environmental, social, cultural, organisational, behavioural and biological factors which may act as barriers to or drivers for health promotion action**

*Do you agree this competency is core to health promotion practice?*

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**Comments**

1. Competence 3.3 and 3.5 can also go under the same competence.
2. Manage problems, deal with barriers and conflicts.
3. Add political.
4. This has to do with the Green & Kreuter systematic planning approach of health promotion.
5. Environment became key problem of public health problem, couldn't be separate from HP and its action.
6. **ADD 'ECONOMIC' TO DETERMINANTS LIST.**
7. Very important.
8. Explain.
**Question 29. Competency 3.6**

Assist populations, communities and groups to articulate their experiences of health needs and to identify capacities for health promotion action

Do you agree this competency is core to health promotion practice?

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<th>Agree</th>
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Comments

1. Not sure if this go under assessment competencies. Other skills/competences are also needed here.
2. To some extent a matter of skills, but also a matter of methods (and methods can be learned and applied).
3. "To articulate experiences of health needs" it is not clear for me.
4. It is not a competency, but an important target/task.
5. DK what 'capacities' for hp action' means.
6. As I understand it, this competence is deeply linked with competence 3.3 (I read the same in both of them).
7. There aren't enough HP professionals. Some countries haven't special programmes of education. Sometimes in the practice they include only specialists. The population and stakeholders could be served with other members of HP team.
8. Depends on your job position.

**Question 30. Competency 3.7**

Identify priorities for health promotion interventions based on consultation and in partnership with key stakeholders, available evidence and health promotion principles

Do you agree this competency is core to health promotion practice?

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Comments

1. This should come earlier? It's also rather overarching, and is the goal of assessment, perhaps should be in the domain statement.
2. I think this is critical if consultations are only expert driven. The results have to be understood as one perspective among others, no more.
3. But we must be able to work on an ongoing process: evidence based practice <-> practice based evidence.
4. Problem is evidence and data collection, we don’t expose with them.
5. Population/target groups.
6. Might fit better under leadership.
**Question 31.**

**Do you think there are any other competencies that should be included in the core domain?**

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**Comments**

1. In principle covered in above mentioned dimensions, but stressed again: openness to views differing from ones own, participation also in assessment!
2. To get together with different disciplines to make a comprehensive diagnosis.
3. Maybe some examples of important assessment methods could be mentioned e.g. employee surveys, environmental analysis.
4. Not necessarily other competencies but comps that are more specific about the bodies of knowledge and skills required to do assessment in the broad way outlined.
5. To be aware about 'The Social Construction of Reality' (Berger/Luckmann, 1966), means there is not such a thing as 'Objectivity'. 'Hard' scientist have some problems with this statement and unfortunately medicine even public health medicine tends to orientate themselves mainly toward pure science.
6. I strongly suggest the inclusion of a not clearly written competence, that I would write as follows: "project, implement, conduct, participate-to surveillance systems, quantitative and qualitative surveys, providing data for action". It involves, for the practitioners, the need of statistical and epidemiological skills. Without these skills, many of the items in the PLANNING domain and others might be empty.
8. See my remark suggesting Research to be a domain. Planning is another important domain. The two together reflect the planning and evaluation approach of Green & Kreuter.
9. This questionnaire is complete guideline, how to develop, implement and realize the art of HP.
10. Ideological, cultural, historical and religious difference should be respected among groups of population and group/minority tailored action should be planed.
11. Money; tools; boundary of the subject; kind of leader you need; kind of worker you need etc.
12. Try to pinpoint – narrow it down.
Question 32. Planning Domain
Developing measurable health promotion 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
Do you agree this domain is core to health promotion practice?

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Comments
1. In principle I agree with measurable goals, but sometimes quantitative measurement at any price results in nonsense (as a trained quantitative researcher I feel that often measuring procedures do not fulfil the criteria of reliability and validity!).
2. There is at least two different ideas in the sentence (measurable goals and strategies based on knowledge etc).
3. And PARTICIPATION.
4. Innovative project management skills are needed.
5. Quality or measurement?
6. In the field of HP it can be very difficult to plan intervention that is based on evidence and practice because of diversity of evaluation in the literature.
7. The complete planning process should be accomplished together with the target group and/or stakeholders of the arena.
8. Would like to see explicit mention of outcomes in this whole section, in the past health promotion and public health have been accused of being output focussed and not being able to demonstrate impact, in the economic climate now and the future outcomes are the key.
9. Planning is essential activity, starting in following instructions from planning domain. Problems are collection and identified data, assessment needs, strategies, which are in preparation now in some countries.
10. Similar as 3.6?

Question 33. Competency 4.1
Develop comprehensive and sequential intervention plans based on an appropriate assessment of needs and assets, theory and available evidence of effective health promotion practice
Do you agree this competency is core to health promotion practice?

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Comments
1. One competence needed as a complement - the competence to quit a plan if it turns out not to be appropriate!
2. Evidences are essential, but you are advised to get them through the available community support.
3. And PARTICIPATION.
4. See 32.
5. DK what comprehensive and sequential means and how feasible that is.
6. Intuition alone, good will and the belief action would be already good in itself is not enough.
7. Develop comprehensive and sequential intervention plans together with the target group and/or arena, based on an appropriate assessment of needs and assets, theory and available evidence of effective health promotion practice.
8. But to develop this kind of sequential intervention we must also have an ongoing permanent evaluation (see PRECEED-PROCEDE model).
**Question 34. Competency 4.2**

**Review health promotion approaches, methods and plans for their acceptability to diverse population groups**

Do you agree this competency is core to health promotion practice?

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**Comments**

1. Through action-research approaches?
2. Two different competencies 1. review hp approaches... 2. adapt it to diverse needs.
3. Review?
4. As part of assessment?
5. More than acceptability, we need an effective participation of communities.
6. Very important.

---

**Question 35. Competency 4.3**

**Identify an appropriate mix of strategies to achieve objectives based on consultation with stakeholders and available evidence of effective health promotion interventions**

Do you agree this competency is core to health promotion practice?

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**Comments**

1. Planning should be more process oriented and participative in decision making in regard to the strategies of intervention.
2. Should be helpful to define consultation/conversation/co-construction?
3. Mixture of competencies and tasks.
4. Not a great deal of difference between 4.1, 4.2, 4.3 to me.
5. Stakeholder analysis is not very common yet.
6. Can be complicated to follow up.
7. Together with the target group and/or stakeholders of the arena identify an appropriate mix of strategies to achieve objectives based on consultation with stakeholders and available evidence of effective health promotion interventions.
8. See comment above on outcomes focus.
9. Incorporation of evaluation at the planning stage, the sustainability stage and issues of funding/donor priorities.
10. On consultation with stakeholders and population groups.
11. Is a mix better than one effective method.
### Question 36. Competency 4.4

**Formulate and communicate appropriate, realistic and measurable goals and objectives for health promotion interventions**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>41.9%</td>
<td>51.2% (44)</td>
<td>4.42</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. What is achieved through health promotion is not always measurable in objective terms - so planning should include the "invisible", hardly measurable steps of significant change - such as trust, motivation, collaboration, genuine participation etc.
2. But also goals which are difficult to be quantified may be important!
3. Who formulates?
5. Together with the target group and/or stakeholders of the arena formulate and communicate appropriate, realistic and measurable goals and objectives for health promotion interventions.
6. More than these actions we must also evaluate attained objectives and goals, and disseminate good practices and results.
7. Should be in participation with the target group.

### Question 37. Competency 4.5

**Identify the resources (skills, personnel, partner contributions, finance, materials, training and support) available and those required to develop, implement and evaluate sustainable health promotion interventions**

Do you agree this competency is core to health promotion practice?

<table>
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<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Mean</th>
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<td>48.8% (42)</td>
<td>4.44</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. This competence overlaps with some of the assessment skills.
2. However some professional may be less involved in planning than others. Front line providers may be informed.
3. Who identifies?
4. Competency or task?
5. Resource Management!
6. See above.
7. Might this be expanded to include the negotiating for and securing of resources?
8. Step-to-step (in each stage).
9. Although I think this is part of the previous phase (needs evaluation).
### Question 38. Competency 4.6

**Develop a feasible action plan and an adequate budget to implement effective health promotion interventions**

Do you agree this competency is core to health promotion practice?

<table>
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<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>54.7% (47)</td>
<td>4.50</td>
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</tr>
</tbody>
</table>

**Comments**

1. Should include the competence of working out of the feasible action the plan, when necessary to respond to the immediate need and changed conditions.
2. Some professional may be less involved in planning than others and spend the majority of their time directly with populations. Depending from level and settings of intervention.
3. Two different competencies.
4. Same as earlier ones? How likely is an HPP to be able to ‘develop a budget’ do you mean accurately cost?
5. Most health promoters in the field have no idea about costs or costs are no matter for them.
6. Same as 4.1.
7. See comment above on outcomes focus.
8. The plan must be an adaptable one, that means that it must fit into ongoing situations during its execution.
9. Budget planning should be separated from this competence and given one of its own. One doesn’t really ‘develop’ a budget so this is the wrong word in any event.

### Question 39. Competency 4.7

**Mobilise support and engage the participation of key stakeholders in health promotion programme and policy development, planning and implementation**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tbody>
<tr>
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<td>59.3% (51)</td>
<td>4.55</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. Since the beginning.
2. NAME?
3. Why is policy development in here, the rest seems to be about planning hp interventions, policy in leadership, advocacy etc?
4. Very important to get things started and working.
5. This is more leadership issue and it is already included in that part.
6. Key stakeholders and community groups.
### Question 40. Competency 4.8

**Develop evaluation plans to assess the process, impact and outcomes of interventions based on health promotion principles and in consultation with key stakeholders**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>57.0% (49)</td>
<td>4.52</td>
<td>86</td>
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</tbody>
</table>

**Comments**

1. I would say - in consultation with key-participants /not key stakeholders.
2. Okay for process but the emphasis on impact and outcomes evaluation may be different. Please take into account that external evaluation is frequent.
3. Check repetition with research & evaluation domain.
4. Process-monitoring is crucial for success.
5. Very important to plan the implementation from the very beginning and think about the barriers.
6. Together with target group and/or stakeholders of the arena develop evaluation plans to assess the process, impact and outcomes of interventions based on health promotion principles and in consultation with key stakeholders.
7. Should have got to this bit earlier in terms of my comments on outcomes.
8. In a "Health Impact Assessment" strategy.
9. This can be part of Evaluation.
10. Develop evaluation and monitoring quality plans with key stakeholders and population groups.

### Question 41. Competency 4.9

**Develop effective feedback mechanisms as part of process evaluation to ensure that health promotion interventions are being implemented as intended and that contingency plans for programme improvement are in place**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>54.7% (47)</td>
<td>4.49</td>
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</tbody>
</table>

**Comments**

1. It belongs to evaluation domain.
2. Check repetition with research & evaluation domain and implementation.
3. But I do not think that having always a plan B in hand is a realistic assumption. I think to have the capability to improvise if it is needed is more important and realistic. It is fallacy to believe that everything can be planned and controlled. The reality is that we indeed learn much more from failure and mistakes than if things going well.
4. Monitoring is crucial. Is it clearly included in the above expression?
5. Develop learning processes in order to facilitate development and people can use it.
Question 42.  
Do you think there are any other competencies that should be included in the core domain Planning?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>20.2%</td>
<td>79.8%</td>
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</table>

Comments
1. Competence for anticipative, multiple-stream planning, beyond the main action plan/program, as open-ending process. Planning under risk conditions, or while experiences continual transition/change.
2. How to get involved since the beginning the target population – PARTICIPATION.
3. It is very important to plan the personal resources.
4. The problem of communication has to be taken into account.
5. Ref to knowledge base of hp planning models.
7. Identify population(s) of interest clearly. Set a positive outcome oriented Goals. Develop measurable indicators associated with each objective and strategy.
8. Narrow it down.
9. Is there any harm?
10. In planning to make the connection to evaluation and sustainability at the planning stage.
11. These competencies reflect the competencies which are necessary to the planning process of health promotion.
12. Accurately cost interventions. Negotiate for and secure adequate resources to undertake interventions.
13. BE APPROPRIATEVELY AND ETHICALLY CREATIVE IN THE DESIGN OF HEALTH PROMOTION STRATEGIES, PARTNERHIPS, AND EVALUATION.
14. NGO, Associations and citizens directly should be included in the planning process because there is lot of participation and voluntary work performed outside the budgetary and funded activities. Their inclusion is also a guaranty and prove for adequacy of measures taken.
15. It is just a normal planning; not specific for HP.

Question 43. Implementation Domain
Carrying out effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources

Do you agree this domain is core to health promotion practice?

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<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<th>Respondents</th>
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<td>50.6% (43)</td>
<td>4.46</td>
<td>85</td>
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</tbody>
</table>

Comments
1. Is ethical clear enough, is it brings everywhere the same meaning... human rights - based is more equally understood.
2. Important - but needs usually competences of more than one individual!
3. I agree with domain itself but not with the statement. This domain should be oriented to defining and using suitable implementation strategies.
4. Description could be more specific.
5. The salutogenic way of health promotion action.
6. Good idea if realistic.
7. Whatever “carrying out” means.
8. Not sure if we might mention it here but certainly in the detail for people to use we should reference tools on equality and diversity impact assessment.
Question 44. Competency 5.1
Use culturally relevant and appropriate health promotion approaches for diverse cultural, socioeconomic and educational groups, and persons of all ages, genders, sexual orientation, ethnicity, health status and abilities
Do you agree this competency is core to health promotion practice?

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<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>1.2% (1)</td>
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<td>37.2% (32)</td>
<td>53.5% (46)</td>
<td>4.43</td>
<td>86</td>
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</table>

Comments
1. Sounds right, but it is not easy to follow, so my question is how the competence could be built around such goal.
2. Not HP approaches but implementation theories, models.
3. Without increasing discriminations between groups and within the entire population.
4. Does it equal diversity management skills?
5. A must in a multi-cultural society and globalized world we are living now.
6. Can be complicated to implement and evaluate.
7. Large part of this is in assessment, part 3.3 for example.
8. It seems more important to me to know one’s limitations because rather few experts are good in approaching all different target groups.
9. It is not specific at all! Of course you have to say yes to this item.
10. Similarities with 4.2.

Question 45. Competency 5.2
Develop, pilot and use appropriate health promotion programme resources and materials in collaboration with stakeholder groups
Do you agree this competency is core to health promotion practice?

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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<td>54.7% (47)</td>
<td>4.42</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Process. what is the competency?
2. How different to 5.1?
3. Right, but don’t forget that we can learn a lot from each other. Somewhere in the world there is probably a solution for that problem someone is facing or has to deal with. Networking becomes in the Internet world its real meaning.
4. This is the previous part, Planning-
5. If possible.
6. And population groups.
7. Has already been said.
Question 46. Competency 5.3  
Implement health promotion strategies using ethical, empowering and participatory processes appropriate to specific contexts  
Do you agree this competency is core to health promotion practice?

<table>
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<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>5.8% (5)</td>
<td>43.0% (37)</td>
<td>51.2% (44)</td>
<td>4.45</td>
<td>86</td>
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</table>

Comments
1. It seems like an empty wording... sorry, I know it is important, but!
2. Description is not very specific.
3. The real meaning of applying the setting-approach.
4. Like in 5.1.
5. What would you do if you implement according ethical, empowering and participatory principles but evidence shows it doesn't work?
6. Isn’t this the same as 44?

Question 47. Competency 5.4  
Ensure that the quality of implementation of health promotion programmes is monitored and meets agreed goals and objectives  
Do you agree this competency is core to health promotion practice?

<table>
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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<th>Respondents</th>
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<td>7.0% (6)</td>
<td>41.9% (36)</td>
<td>51.2% (44)</td>
<td>4.44</td>
<td>86</td>
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</table>

Comments
1. Yes in terms of monitoring, but not on what - the process of HP is key issue to monitor, and then the goals and objectives.
2. Too theoretical statement.
3. And critical stance ... since in the real world things are more complex.
4. Without losing the flexibility to change in case of detection of wrong or less adequate strategies.
5. Agree but belongs to quality management and evaluation skills.
6. Often unintended achievements are much more important than the planned goals.
7. Check reps with evaluation.
8. Quality management and monitoring tools and/or instruments which have often at first programme-specific to be developed are important requirements.
9. Process indicators that are evaluated need to be flexible.
10. And outcomes.
11. it is not said that this should be done by the HP practitioner.
12. I would say: elaborate an evaluation plan with attention to both process and outcome measures.
Question 48. Competency 5.5
Use feedback from process evaluation to maintain and improve the effective implementation of planned health promotion interventions
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<th>Respondents</th>
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<td>4.51</td>
<td>86</td>
</tr>
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</table>

Comments

1. It should be a part of Evaluation domain.
2. See 5.4.
3. Check reps with evaluation and above.
4. Particularly for a health promotion intervention the feedback of the target group is relevant and probably the best indicator for success.
5. This should be part of the suggested research domain.
6. Also need to highlight that implementation will also need to include time given to impact and/or outcome evaluation e.g. time given over to survey participants pre and post implementation.

Question 49. Competency 5.6
Manage resources, including the necessary staffing, skills and budgets needed for the effective implementation of health promotion interventions
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>51.2% (44)</td>
<td>4.42</td>
<td>86</td>
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</table>

Comments

1. See precedent answers: planning/coordination vs field.
2. As already said: The success of a health promotion programme or intervention is depend on having a good project manager (male or female, it doesn’t matter) with excellent managerial skills.
3. Is often underestimated.
4. Requires management skills partly beyond HP competences.
5. There are so many competences that should be trained within a few years of graduate level and/or post graduate. Am not sure that the above in #49 should be prioritised in the academic training oh health promotion practitioners. Would be lovely to reach all academic objectives, but one needs to be realistic.
6. This is part 4.5 again.
7. Effective and contextualized implementation.
8. Already been said under leadership.
**Question 50. Competency 5.7**  
Facilitate programme ownership and sustainability of effective health promotion interventions through ongoing consultation and collaboration with key stakeholders  
Do you agree this competency is core to health promotion practice?

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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<td>45.3% (39)</td>
<td>4.35</td>
<td>4.37</td>
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</table>

**Comments**
1. Belongs to Partnership domain.
2. =target (competency = partnership development skills and participation methods?)
3. Sometimes diplomatic action is useful but with standing. Opportunism will fail at the end.
4. Stakeholders and population groups.
5. Depends on your position.

**Question 51.**  
Do you think there are any other competencies that should be included in the core domain Implementation?

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<th>No</th>
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<tbody>
<tr>
<td></td>
<td>7.1% (6)</td>
<td>92.9% (78)</td>
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</table>

**Comments**
1. A very relevant issue.
2. But I think that this domain should be revised.
3. Creating nice plans is easy, implementation is the tough job.
4. Maintenance and sustainability.
5. If all these competencies available and on demand to activate that would be really excellent.
6. Facilitating HP to be part of all policies (health in all policies), being a necessary starting point for implementing HP.
7. The involvement of the voluntary sector - NGO, Associations, citizens.
8. Narrow down.
**Question 52. Evaluation and Research Domain**

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.

Do you agree this domain is core to health promotion practice?

<table>
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<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<th>Respondents</th>
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<td>54.7% *47)</td>
<td>4.45</td>
<td>86</td>
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</table>

**Comments**

1. If these competencies are made up for practitioners why to include “research” domain? I would suggest to use just the Evaluation domain.
2. For health promotion practitioner’s evaluation is a must, but I am not sure about the research component.
3. This is important because it helps to avoid frustration and disappointments if the set goals are very ambitious or unrealistic.
4. In my opinion, evaluation should be identified as a different domain. Some public health agencies, as CDC, distinguish "practical evaluation" from "scientific evaluation". Practical evaluation is a tool of the practitioner. Scientific evaluation is in the research domain. We cannot establish a perfect separation between the two types of evaluation, but this idea is useful in the public health practice.
5. Reach, effectiveness, efficacy yes, impact probably no, if the impact on individual’s health is meant.
6. I am very uncertain about to which degree a student of graduate level will possess.
7. Regarding scientific and research competence as complex described in #52-61.
8. It is not necessary and advised that this work should be done by the HP practitioner him/herself; it should just be organised by the HP worker!
9. Research appears to have been reduced to evaluation of practice. Practitioners need to have competencies to influence and undertake research beyond simply measuring the effectiveness of interventions. I would argue for some consideration of what broader research competencies we might expect of practitioners.

**Question 53. Competency 6.1**

Incorporate evaluation into the planning and implementation of all health promotion activities.

Do you agree this competency is core to health promotion practice?

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<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tbody>
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</table>

**Comments**

1. HP stages and activities.
2. It would mean that the HP evaluation indicators would be inserted in the planning process since the beginning.
3. Is no competency but a task/process.
4. Very important often the idea of evaluation comes too late.
5. Appropriate evaluation.
6. Incorporate "practical evaluation", not scientific one. We do not need a community trial for our practical hp programme.
7. See comment above. The research should not be done by the HP specialist. He/she should organise the research to be done.
### Question 54. Competency 6.2
Identify the need for, and engage with technical and research expertise as required to develop and apply research methods for monitoring and evaluation

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>47.7% (41)</td>
<td>4.30</td>
<td>86</td>
</tr>
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</table>

**Comments**

1. Engage with technical and material resources, and research expertise
2. People themselves have their own expertise too.
3. As above.
4. In collaboration with research staff.
5. Why would we not expect practitioners to have the competence to develop and apply research methods for monitoring and evaluation themselves. Whilst many practitioners may not currently have this competence, we appear to be saying 'don't worry if you can't do it yourself - just call in the experts'. The engagement of 'experts' isn't considered necessary in any of the other domains.

### Question 55. Competency 6.3
Use appropriate health promotion evaluation and monitoring methods incorporating process, impact and outcome measurement, in partnership with stakeholders

Do you agree this competency is core to health promotion practice?

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<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</table>

**Comments**

1. I strongly agree!
2. Sure for process. May be more difficult for front line to take into account impact and outcomes.
3. And population groups
4. Has been said under implementation.

### Question 56. Competency 6.4
Apply evaluation findings to refine and improve health promotion interventions and support the sustainability and dissemination of effective practice

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>4.53</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. Means generating evidence and improve the body of knowledge (knowledge management).
2. Duplicates process evaluation items.
3. Effective and contextualized practice.
4. I suggest to skip the work 'dissemination' which is more relevant to item 6.6.
5. Had been said under implementation.
**Question 57. Competency 6.5**

*Communicate clearly evaluation findings to diverse stakeholder groups*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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</tbody>
</table>

**Comments**

1. This could go together with the competence 6.4.
2. It is no competency but a quality criterion for good evaluation practice.
3. The opposite of whitewashing. Important to add: What are the consequences of the findings for health promotion practice?
4. Check doesn’t duplicate communication comps - this is not a competency in own right but a task.
5. Mostly to policy decision-makers and to funding possible partners.
6. Stakeholders and population groups (lay people).

---

**Question 58. Competency 6.6**

*Critically consider the practice and policy implications of findings from the monitoring and evaluation of health promotion activities*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</tbody>
</table>

**Comments**

1. It is no competency but a quality criterion for good evaluation practice.
2. Politicians do not like this mostly they want often only to announce improvements and success.
3. Senior ones.
4. I am very uncertain about to which degree a student of graduate level will possess regarding scientific and research competence as complex described in #52-61.
5. Strongly agree with statement on criticism.
Question 59. Competency 6.7
Contribute to the advancement of health promotion knowledge and practice through the use of research and evidence-based strategies
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>52.3% (45)</td>
<td>4.37</td>
<td>86</td>
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</tbody>
</table>

Comments
1. Also 6.6 could go with 6.7.
2. Competency or target/vision?
3. This means everybody has to be very cooperative and collaborate even if there is a lot of competition in the field. But the willingness to cooperate and to collaborate is very often determined by limited resources, budget and funding.
4. Repetition.
5. Not all practitioners may have the opportunity to do this.
6. Is it realistic to talk about evidence when talking about community based approach?
7. Senior ones.
8. At senior level.
9. Sometimes there is more advancement in applying new strategies because there is few evidence in setting based approaches compared to lifestyle-interventions.

Question 60. Competency 6.8
Contribute to planning, conducting and writing health promotion evaluation initiatives and preparing research proposals for funding
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Mean</th>
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<td>4.34</td>
<td>86</td>
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</tbody>
</table>

Comments
1. Should we consider this aspect as a part of the core?
2. I agree, but this is first of all the business of researchers and academia, means health promotion practitioners do often not have the time and the required knowledge for this.
3. This is a muddle of some repeated items, and other comps. eg preparing research proposals for funding requires a high level set of research comps?
4. maybe more simpler evaluation proposals or participate in to be done by academics.
5. I am very uncertain about to which degree a student of graduate level will possess regarding scientific and research competence as complex described in #52-61.
6. Again I agree, but feel that practitioners should have competence to undertake research as well as contribute to proposals.
7. I think this is important but very specific as a competence everybody working in health promotion should have.
Question 61. Competency 6.9
Review and disseminate relevant health promotion research and literature
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>50.0% (43)</td>
<td>4.37</td>
<td>86</td>
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</tbody>
</table>

Comments
1. Experience is more than just research an literature - but how to share this?
2. Methods of dissemination would be evidence based, too.
3. Communication comp?
4. This might be too demanding, needs special expertise.
5. This is the objective in academic training of graduate level. my opinion is that the students need more training before they do this kind of disseminations, at least independently. In a partnership with more experienced professionals it would probably be ok.
6. Not just health promotion research and literature, practitioners need the skill to utilise intelligence from a much wider range of sources than those traditionally thought of, that is really one of our unique selling points that we do recognise that material from non traditional health sources can have equal and sometimes more value.
7. Has been said?

Question 62.
Do you think there are any other competencies that should be included in the core domain Evaluation and Research?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.5% (13)</td>
<td>94.5% (71)</td>
</tr>
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</table>

Comments
1. Give equal chance to qualitative as well as quantitative evaluation and research data in decision making, planning, strategies of intervention.
2. Scientific reports are an important means to communicate evaluation results. But results also need additional ways of dissemination - not only cognitive also more sensitive ways - films, stories, pictures.
3. Improve methods of action- research.
4. Because evaluation is a critical point there should be other options recommended.
5. Yes, I think, there is a need for low-level evaluation methods and tools with are easy to handle for health promotion practitioners in their field work particularly if the do not have a specific academic background.
6. Except as for all these domains the core underlying knowledge and skills specific to the domain is not clearly stated.
7. Please, look at the point 52. I am not sure that evaluation and research should be included in the same domain.
8. Important to plan the evaluation at the same time as planning the implementation.
9. It may be relevant to mention "qualitative and quantitative" when asking about research and evaluation methods (in the context that research culture in some countries (if health promotion is under influence of biomedical paradigm) still has a tendency to disqualify qualitative methods as "non-scientific” ones.
10. Make clear distinction between what to be done by the HP worker him/herself and what must be organised by HP worker for doing by others.
11. Some basic skills in planning and undertaking qualitative and quantitative research are necessary, and should be included in this domain.
12. Beside review and dissemination of expert articles... also a more user friendly, practical and simple review and dissemination for a public use of the citizens is needed.
### Question 63. Advocacy Domain

*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.*

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<td>4.41</td>
<td>86</td>
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</tbody>
</table>

**Comments**

1. Could be more specific.
2. Too narrow to individuals and communities - there are other settings with other conditions.
3. Advocacy was and is one of the three premises of action in the Ottawa Charter and seems nowadays more relevant than twenty years before. Means health promotion is a matter of political action, giving people a public voice.
4. More a task for NGOs or different bodies.
5. Not easy to understand what exactly is meant.
6. Explain, it is very wide.

### Question 64. Competency 7.1

*Identify and create opportunities to advocate for and with individuals, groups, communities and organisations to improve their health and address health inequities.*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>47.7% (41)</td>
<td>4.43</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. Description not very specific.
2. Power to the people!
3. See above.
4. See final narrative box.
Question 65. Competency 7.2
Identify strategic alliances and mechanisms for advancing health promotion policy and practice
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>48.8% (42)</td>
<td>4.41</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Okay for practice but uncertain for policy.
2. Yes, but strategic alliances have to focus on the issue how much control people have over their living environment and working conditions and not to force them too more healthy behaviour.
3. Check meaning and overlap with partnerships.
4. Can be difficult to follow up on.
5. Maybe.
6. This is more leadership, and I am sure it is there already.
7. In a "Health in all policies" approach.
8. Same meaning as 64.

Question 66. Competency 7.3
Identify critiques of health promotion and develop strategies to respond to them
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
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<th>Disagree</th>
<th>Uncertain</th>
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</tbody>
</table>

Comments
1. This competency is more suitable for researchers as for practitioners.
2. Doing the right thing is the question, not doing things right, this is only the technical part of that question how to achieve a good life or rather a good quality of life.
3. Do you mean ‘critics’?
4. The best strategy is the dissemination of health promotion intervention results and outputs.
**Question 67. Competency 7.4**

Develop, implement and evaluate advocacy plans for health promotion using a range of advocacy strategies and techniques

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>4.20</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. It should be the part of planning process/domain.
2. Sounds like a sweeping one again, the competency is in the K&S of advocacy strategies and techniques.
3. What work can be very different between cultures.
4. See above.
5. Please check, how many plans should a health promotion practitioner (environmental planner or researcher) develop, implement and evaluate and try to find remaining life time for simple work...I am sorry.

**Question 68. Competency 7.5**

Raise awareness and influence public opinion on health promotion by identifying and accessing relevant media and disseminating a range of resources and information

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>51.2% (44)</td>
<td>4.43</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. Targeted approaches sometimes do not need so much media involvement. The need for media involvement depends on the communication habits of the addressed communities.
2. Methods for risk communication should be developed.
3. Public relation competencies or social marketing.
4. I am critical about using public media since we know that their impact on public opinion is limited by the factor of cognitive dissonance. In addition traditional media only allow a passive perception and can therefore have a manipulative effect if they promise change by buying a certain product. More interesting today are the new opportunities given by the social communities in the Web 2.0. They are dialog-based and have a democratic potential that is able to balance the business and expert driven world.
5. Check overlap with 6.9
6. This is in leadership and assessment already.
7. This might include media professionals training in health promotion (for example: the inclusion of a health promotion module in media professional pre-graduate training).
8. Media became more and more advocate for HP, but they need to get also knowledge and education. They are specialised displaying information, but journalists need special knowledge about HP.
9. Depends very much on your position.
Question 69. Competency 7.6
Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non-governmental organisations) on the development and implementation of health promotion policies and programmes
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>58.1% (50)</td>
<td>4.53</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Sometimes it is enough to get the target groups and you do not involve decision makers.
2. Check overlap with partnerships.
3. Could also be uncertain when referring to national level.
4. Same comment as above.
5. But not just health promotion policies and programmes they have to be able to influence education, justice, culture, economics etc; really the Social Determinants of Health and therefore the health promotion contribution to those other policies.
6. Means healthy people, methods, introducing activities and bring together people, citizens, different consumers, who would like to get better lifelong quality HP and environment. Here is included HP for ill / rest of f quality of life/ by different survivors, handicapped, invalids. At this level is important to work for LC, where people are living and doing, realizing their needs, leisure time, sports ...NGO’s are very good environment for personal growth, be a friends, working together, There are sometimes leading force, very good partners which are progress in HP oriented.
7. More a senior level competence.
8. Depends very much on your position.

Question 70. Competency 7.7
Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>33.7% (29)</td>
<td>4.12</td>
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</table>

Comments
1. Paper will not impact without face to face contacts.
2. And eventually other actions depending on the situations.
3. What is the competency - not the task.
4. Could also be uncertain, at least for juniors - especially since there is no specification if this could be done in collaboration with decision makers
5. This is a political task, and yes, we need public health politicians. Nevertheless and once again: these kind of lobbying processes might be paternalistic and/or normative. I’d rather see a health promotion practitioner that (after have been asked so) supports the target groups and/or the stakeholders to do the lobby process!
6. See final narrative box.
7. More and more members come as active supporter and are willing and like understand and be involve in common goods and advocacy lobbying process of HE.
8. Depends very much on your position.
Question 71. Competency 7.8
Enable and support communities in the articulation of their views and concerns about health and health inequities
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>41.9% (36)</td>
<td>4.27</td>
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</tbody>
</table>

Comments
1. Don’t understand. It sounds very paternalistic. Is it to help to clarify the critical understanding of the situation?
2. Is this a competency or a target/vision of health promotion?
3. EmPOWERment!
4. Why only health inequalities? why not also cancer, climate change, heart disease, smoking, alcohol, bad quality of life, volcanic ash distribution, etc.
5. We must understand the difference between what communities want and what communities need regarding health (it is not always the same)
6. This item expresses the philosophy / foundations of advocacy and should be placed at the beginning of advocacy domain.

Question 72. Competency 7.9
Contribute to influencing and shaping organisational, multiagency, regional and national agencies to maximise opportunities for health promotion and reduce health inequities
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>41.9% (36)</td>
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Comments
1. Not very specific.
2. Yes, but this means we have to break the rules and to define new rules and regulations, NOT follow the existing rules.
3. see above
4. Might this better read “..... to maximise opportunities to promote (or improve) health.....” as it might otherwise be implied we are looking to maximise opportunities for ourselves as HP practitioners.
5. Some people are willing to work in reducing health inequities, helping and give support and influence to community, LC, politicians to ask their right for HP and HC services.
6. Depends very much on your position.
**Question 73. Competency 7.10**

Advocate for the development of policies, guidelines and procedures which impact favourably on health and reduce health inequities and provide health promotion input into their development.

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>45.3% (39)</td>
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</tbody>
</table>

**Comments**

1. Don’t understand the way it is formulated.
2. Mixture of vision and competency.
3. See above.
4. The inclusion of a Health impact report in all decisions (like environmental impact report) must be a fundamental aim of this competence.
5. We need systematic work with governments, Parliaments and presentation of HP through mass media.

---

**Question 74.**

Do you think there are any other competencies that should be included in the core domain Advocacy?

<table>
<thead>
<tr>
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<th>No</th>
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</thead>
<tbody>
<tr>
<td>11.9% (10)</td>
<td>88.1% (74)</td>
</tr>
</tbody>
</table>

**Comments**

1. To enable people to think by themselves and to find out or to build mechanisms to be heard
2. More focus on advocacy methods would be interesting - public media campaigns/social marketing skills - organise meetings with stakeholders, events - develop guidelines - develop policies
3. The ability to set up a powerful social movement for health, creating civil society for health.
4. As before be clearer about the competencies rather than listing the tasks required.
5. Opposite, too much.
6. The problem may be (as it happens) how to separate all these very needed activities from what is called involvement in political activities
7. See notes in boxes above, practitioners need to recognise the true political dimensions of their advocacy role in relation to who their employer is, if you are in civil society then you have more freedom if you are employed by any part of National, Regional or Local Government you do not so one needs to give these skills and competencies to both protect practitioners and their clients.
8. Where education, HP, is included in all curricula, whole education process, we can expect big change in mortality and morbidity on global level. It’s time, to implement and use new approach everywhere start to use the data on HPE standards.
9. Beside a typical advocacy a legislative approach should be taken, so that there would be a must for a minimum level of health promotion performance, like taking health effect into account by each communal or other decision adopted at local, regional and national authority level with an impact on the quality of life and health of citizens.
10. I wonder what's the value of this, at European level. It is so self-evident. I think f.e. it is important to make a local/regional analysis of the players and define each role and responsibility. That's more specific.
11. Have to narrow down.
Question 75. Partnership Domain

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

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
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<th>Agree</th>
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<td>62.8% (54)</td>
<td>4.60</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments

1. And to better understand the diagnosis and the processes.
2. Health Promotion only works as collaborative action. Everybody knows this but in practice the department structures are difficult to overcome because behind them there are often very closed expert cultures and communities with their own professional language and communication codes.
3. And recognise health promotion contribution to other programmes and policies.
4. The development of transdisciplinary studies in health promotion is a central need in Europe development. EU should fund the development of this kind of advanced training.
5. Partnership domain along with leadership is a basic approach / principle of HP. Both should be placed together, on the front of list (as domain 1,2, or 3).

Question 76. Competency 8.1

Identify partners within and outside the health sector with the potential to support the development and implementation of health promotion policies and programmes

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
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<tbody>
<tr>
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<td>55.8% (48)</td>
<td>4.53</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments

1. Important but not easy. Good communication and even more negotiation skills are required.
2. Why mention the health sector and no other sectors? Sounds a bit like that everything starts with the health sector, which is not the truth, even if they have a huge potential.
3. Mostly outside health sector.
4. It is a competency for senior level.
5. Depends very much on your position.

Question 77. Competency 8.2

Facilitate intersectoral collaboration and build partnerships for health promotion using leadership, team building, negotiation and conflict resolution skills

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
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<td>1.2% (1)</td>
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<td>37.2% (32)</td>
<td>59.3% (51)</td>
<td>4.55</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments

1. Finding common vision and interests. Negotiation on the basis of “win-win” situations.
2. But my personal experiences in the last twenty years dealing with medical doctors are that they probably have the biggest problems to understand the relevance and to accept the necessity to learn and to acquire those social soft skills.
3. But how?
**Question 78. Competency 8.3**  
Establish and maintain effective partnership working with key health promotion stakeholders, including statutory bodies, community groups and voluntary/non-governmental organisations

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>1.2% (2)</td>
<td>37.2% (32)</td>
<td>59.3% (51)</td>
<td>4.55</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. Is it only the health promotion practitioner that should be responsible for establishing and maintaining effective partnerships? If the responsibility is all the health promotion practitioners than he/she will be seen as an expert, which in turn will lower the activity in others.
2. Do not forget the private sector as in some countries such as Germany it is the Insurance companies which fund a lot of health promotion work in schools and Communities.

---

**Question 79. Competency 8.4**  
Develop and sustain local, regional and national coalitions and networks for advancing intersectoral health promotion policies and programmes

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>2.3% (2)</td>
<td>47.7% (41)</td>
<td>48.8% (42)</td>
<td>4.44</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. See advocacy.
2. Networking for certain purposes and on time limited by a project, yes, but not as an open-end structure. That it is working is also a matter of its size and whether the involved people have decision-making powers.
3. Is it only the health promotion practitioner that should be responsible for developing and sustaining effective partnerships? If the responsibility is all the health promotion practitioners than he/she will be seen as an expert, which in turn will lower the activity in others.
4. With a strong local development process due to the need of cultural and socio-economic approach in health promotion programmes.
5. Depends very much on your position.

---

**Question 80. Competency 8.5**  
Mediate between different sectoral interests and manage the partnership process in the development and implementation of health promotion policies and programmes

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>10.5% (9)</td>
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<td>38.4% (33)</td>
<td>4.26</td>
<td>86</td>
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</tbody>
</table>

**Comments**

1. A wish - but how realistic?
2. Leadership.
3. This is where Political awareness comes into its own.
**Question 81. Competency 8.6**

**Review the effectiveness of partnerships and collaborative working for health promotion and make recommendations for improvements**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Mean</th>
<th>Respondents</th>
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<td>43.0% (37)</td>
<td>4.37</td>
<td>86</td>
<td></td>
</tr>
</tbody>
</table>

Comments

1. With attention to the contexts. Knowledge translation
2. Task.
3. Evaluation and research.

**Question 82.**

*Do you think there are any other competencies that should be included in the core domain Partnership?*

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>7.1% (6)</td>
<td>92.9% (78)</td>
</tr>
</tbody>
</table>

Comments

1. Public-Private-Partnership. Since most of the municipal government budgets are deep in debt, some close to bankruptcy (and this will not changing in the near future) there is a need for PPP activities. What in my opinion is really missing in the health promotion area is an understand about the relevance of economy for societal development or according to Amartya Sen for the fundamental requirements for health: Freedom and Development.
2. Check overlaps with other domains.
3. To be able to follow up on recommendations that could come out of this paper could be very difficult.
4. Networking
5. ABIDE BY ETHICAL PRINCIPLES AND CONSIDER POTENTIAL IMPACT ON EFFECTIVENESS OF HEALTH PROMOTION STRATEGIES AMONG TARGET AUDIENCES IN CHOOSING PARTNERS FOR COLLABORATION.
6. The proposed competencies are correct but they are also to idealistic. They all exist in the reality but are not so effective as expected. Some statement should also be taken about competencies on the negative side of the problems appearing that are more connected with reality in the every-days life and non effectiveness of existing partnerships that call for improvement measures.
7. These marks goes well with leadership. Maybe rework them together.
**Question 83. Communication Domain**

*Communicating health promotion activities and programmes effectively using appropriate methods for diverse audiences*

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Mean</th>
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<td>4.62</td>
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</tbody>
</table>

Comments

1. Pre-test.
2. Do good things and talk about that!
3. this should be organised but not necessarily be done by the HP worker him/herself. Sometimes it is better to let this be done by a communication specialist!
4. Think these are largely covered elsewhere, particularly in the Advocacy section.

---

**Question 84. Competency 9.1**

*Communicate and disseminate data and information on health promotion policies and programmes to a range of diverse audiences*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tbody>
<tr>
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<td>40.7% (35)</td>
<td>55.8% (48)</td>
<td>4.52</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments

1. Focus on HIS (HEALTH INFORMATION SYSTEMS) and quality of data.
2. Process - what is the competency?
3. But, please, focus on good and/or best practice and highlight lighthouse projects.
4. Agree - but this is covered in the advocacy section.

---

**Question 85. Competency 9.2**

*Use the media, advanced technologies and relevant networks to receive and communicate information on health promotion*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>43.0% (37)</td>
<td>53.3% (46)</td>
<td>4.48</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments

1. Both 9.1 and 9.2 can merge in one competence.
2. PR specialist know how to do it. I guess health promoters can learn a lot from them.
3. Media, interpersonal and community events, advanced.
4. And associated topics.
5. Advise by a communication specialist is necessary.
6. Yes - but covered in 7.5.
7. Depends on your target group and aim.
**Question 86. Competency 9.3**

*Develop and disseminate written, oral and electronic communication (including reports, presentations and focused messages) on health promotion policies and programmes tailored to specific contexts*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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</thead>
<tbody>
<tr>
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<td>0.0% (0)</td>
<td>5.8% (5)</td>
<td>50.0% (43)</td>
<td>44.2% (38)</td>
<td>4.38</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. I can not see the difference with 9.1.
2. But needs also other means of information dissemination.
3. About analysis of the successes and failures.
4. Journalists, PR specialist and communication professionals should be won for collaboration. They have the expertise which is needed.
5. Creating an image for communication activities.
6. Possibly with assistance of professionals in communication..?
7. Again 7.1 and 7.5 might cover this or vice versa.

**Question 87. Competency 9.4**

*Use effective and culturally appropriate health promotion communication methods, techniques and language suitable for specific population groups*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td></td>
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</tr>
</tbody>
</table>

**Comments**

1. This is also repeating to some extend with 9.3, or both could be stated in one sentence.
2. Yes, but communication is not a matter of applying sociotechnical methods. It is much more about empathy and respect.
3. Its is already there earlier.
4. Not sure this adds anything to 9.3

**Question 88. Competency 9.5**

*Apply interpersonal communication and groupwork skills to facilitate individuals, groups and communities to increase control over their health and reduce health inequities*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>9.3% (8)</td>
<td>39.5% (34)</td>
<td>51.2% (44)</td>
<td>4.42</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. Especially groupwork skills are very important.
2. See 9.4.
3. Too broad, how does it differ from next one or others? Key K&S are in individual and group communication skills.
4. Leadership.
Question 89. Competency 9.6
Apply a range of communication skills to facilitate the development of personal skills and community action to improve health and reduce health inequities
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tbody>
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<td>48.8% (42)</td>
<td>4.41</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Not sure this adds anything to 9.5.

Question 90. Competency 9.7
Promote and debate the merits of diverse health promotion strategies using ethical, theoretical and evidence-based arguments
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>47.7% (41)</td>
<td>4.29</td>
<td>86</td>
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</tbody>
</table>

Comments
1. And listen the point of view of those interested in improving.
2. Yes, I think, we need an open and critical discourse about all those relevant aspects within the international health promotion community.
3. With whom, why? repeats others earlier eg 7.3 etc.
4. Probably requires very advanced skills from practitioners.
5. And also practice based arguments (good practices).
6. Again covered in advocacy.
Question 91.
Do you think there are any other competencies that should be included in the core domain Communication?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.</td>
<td>o recognize and continually support communities, individuals, as well as the policy decision makers in their efforts to carry on HP initiatives, and change.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Communication is not just dissemination but communication is also the willingness and ability to listen.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>To be able to listen</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Different disciplines using different languages. How to overcome?</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>But it should be very clear that communication is not a question of applying an adequate communication technique; communication means in fact doing interpersonal relation work and not just exchange information.</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Training is a typical tool of public health and HP practitioners. In this document training is not identified as a specific domain. Might be it included in the Communication domain? Otherwise, training should be an autonomous domain. Training competence involves a number of theories, attitudes and skills. Training should be integrated with other HP activities, described in this document.</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Mind the gap of the HP specialist being a communication specialist!</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>We have good example: workshop for strengthen self esteem through communication develop communication and understanding self.</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Introduce informative content of public health promotion in the curriculum of health education institution to inform students as future health providers with evidence and information on this topic.</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>I think you can narrow down this to 3 marks.</td>
<td></td>
</tr>
</tbody>
</table>

Question 92. Knowledge Domain
Demonstrate understanding of, and the ability to apply in practice, the theory, research and ethical dimensions of health promotion and the multidisciplinary knowledge base which underpins the competencies listed above
Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td></td>
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<td>40.7% (35)</td>
<td>52.3% (45)</td>
<td>4.44</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Competencies are a set of knowledge, abilities, skills and attitudes in interaction so it seems difficult to identify them apart as a 10th domain. However I agree the proposed knowledge are essential to health promotion practice.
2. It has an affective domain, always.
3. Very ambitious but after more than twenty years of not always very encouraging practical exercises in the field there is a need for a new base-line to conceptualize, to develop and finally at least to implement promising health promotion action or intervention programme.
4. Do not think that knowledge is a domain in its own right. The other domains are largely lacking their knowledge base, and this does not cover the whole knowledge base for HP, however it does include some of the key body of knowledge a HP needs, but should not be separated out here. Have answered items below on agreement that they should underpin HP, not agreement to standing in separate domain - demonstration of all these should be through the other competencies.
5. Demonstrate to whom.
Question 93. Competency 10.1
Demonstrate knowledge of the history and development of health promotion internationally, including the Ottawa Charter (WHO, 1986) and successive charters and declarations as the foundations for health promotion practice
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>41.9% (36)</td>
<td>48.8% (42)</td>
<td>4.38</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Appreciation is not measurable. Perhaps another word to demonstrate the ability to do this.
2. Good but there are also other pathways.
3. I agree, but I guess all those documents in WHO speak are a bit overestimated. For example: Don Nutbeam’s & Elizabeth Harris' "Theory in a nutshell: A guide to health promotion theory" is to me more suitable and instructive than all these charters and declarations.
4. Very important to build on the Charter, this paper is far more comprehensive and kind of unrealistic to work with.
5. This is often taken too far and seen as ‘jargon’ by lay people.
6. As in 9.2 above would add the word ‘understanding’ as knowing something and understanding what it means and how to use it are not the same thing.
7. Core documents "like Bible" of HP.

Question 94. Competency 10.2
Demonstrate understanding of the core concepts and principles of health promotion and their application in practice
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
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<td>1.2% (1)</td>
<td>40.7% (35)</td>
<td>57.0% (49)</td>
<td>4.53</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Pay attention to the instruments of such "knowledge demonstrations".
2. See 10.1.
3. There has to be focus on HP related to the Ottawa Charter.
4. Same as 10.1.

Question 95. Competency 10.3
Demonstrate understanding of the concepts of health inequalities and inequities, their impact on health status and their relevance for health promotion policies and programmes
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>1.2% (1)</td>
<td>2.3% (0)</td>
<td>39.5% (34)</td>
<td>57.0% (49)</td>
<td>4.52</td>
<td>86</td>
</tr>
</tbody>
</table>

Comments
1. Yes, but the main emphasis should be put on 'equity' and 'social justice'. We will always have inequalities this is not the point of interest are the gaps between social groups and how steep the social gradient is in a society. This is a matter of social justice or rather social injustice.
2. I disagree with limiting all to health inequalities...we are creating huge inequalities.
3. Linked to 10.6 below?
4. Understanding essential concepts of health inequalities and inequities could lead to the right solutions.
**Question 96. Competency 10.4**

Demonstrate understanding of the theories, research and multidisciplinary knowledge base underpinning health promotion and their application in the development and implementation of health promotion practice, policy and research.

**Do you agree this competency is core to health promotion practice?**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
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<tbody>
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<td>3.5% (3)</td>
<td></td>
<td>45.3% (39)</td>
<td>50.0% (43)</td>
<td>4.44</td>
<td>86</td>
</tr>
</tbody>
</table>

**Comments**

1. Pay attention to the instruments of such "knowledge demonstrations".
2. With the participation of the others and to know how to build coalitions.
3. Especially theories in health psychology,
4. There is a need to defragmentise our very specialized expert driven knowledge, deconstruct and reconstruct it in order to gain new insights and a new understanding of the context conditions for our life.

**Question 97. Competency 10.5**

Demonstrate knowledge and understanding of the ethical dimensions of health promotion and their application in practice.

**Do you agree this competency is core to health promotion practice?**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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</table>

**Comments**

1. Appreciation is not measurable. Perhaps another word to demonstrate the ability to do this.
2. See 10.4.
3. Don’t understand this! Why introducing a specific model here?

**Question 98. Competency 10.6**

Demonstrate understanding of the importance of context for practice based on the socio-ecological model of health promotion.

**Do you agree this competency is core to health promotion practice?**

<table>
<thead>
<tr>
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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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</table>

**Comments**

1. See 10.4.
2. Don’t understand this! Why introducing a specific model here?
Question 99. Competency 10.6

Demonstrate knowledge of the social, environmental, behavioural and biological determinants of health and their implications for the development of effective health promotion policies and programmes

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
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</table>

Comments

1. Most so-called determinants are man-made and therefore there are not only options to change them but it is up to us to change them.
2. See comment above.
3. This is inherent of planning competencies.
4. Present situation in EU and global world ask immediate adaptation on new changes, reflecting in HP policies and programmes.
5. ADD ‘ECONOMIC’ TO DETERMINANTS LIST.

Question 100. Competency 10.8

Demonstrate awareness and knowledge of the impact of local, national, regional and international health systems, policies and priorities and their impact on health promotion practice

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Agree</th>
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Comments

1. I would like the public health and/or health promotive objectives at local, national, regional and international level to be mentioned above, even if the probably are to be seen as integrated in "policies". The objectives are there to guide us in the prioritising and are therefore extremely important to know.
2. Most important would be to know the impact on health rather then on a discipline even if the discipline is health promotion.
3. Not just health systems, practitioners need to understand how other systems impact on their work and vice versa e.g. how the education system works if you want to introduce health promotion into the school.

Question 101. Competency 10.9

Demonstrate knowledge of, and sensitivity to, social and cultural diversity in all aspects of health promotion practice

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
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<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</table>

Comments

1. Too broad and abstract.
2. this is context, so 10.5.
**Question 102.**
*Do you think there are any other competencies that should be included in the core domain Knowledge?*

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td></td>
<td>17.9% (15)</td>
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</table>

**Comments**

1. Demonstrate knowledge of the holistic, participatory and action oriented approach to HP, in diversity of settings - demonstrate understanding of the vital link between the human' and children' rights and the HP policy and practice.
2. Some knowledge about basic contributions of various sciences to HP - epidemiology, psychology, political science etc. - needed to understand the multidisciplinarity of HP - who to involve to achieve certain goals.
3. How to build partnerships.
4. Knowledge and experience about what are ones competencies and where are the limitations/ when it is necessary to work with experts/partners/teams.
5. Knowledge Management, Knowledge Database, Shared knowledge across disciplines, particularly between science and social sciences.
6. Other areas of knowledge need to be specified as indicated.
7. Demonstrate knowledge of the theories, models and strategies of behaviour change to health.
8. Knowledge of policy and political context.
9. I’d like to see something that covered knowing how organisations, communities, etc ‘work’. Something along the lines of: Demonstrate knowledge / understanding of systems that operate in different environments and settings.
11. Demonstrate knowledge of how settings, which should be changed, work.
12. These have more to do with values within the field of HP. I don't know if the title Knowledge is correct.
### Question 103. Domains

**Are there any domains that you would like to see added to the framework document?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14.3% (12)</td>
<td>85.7% (72)</td>
</tr>
</tbody>
</table>

**Comments**

1. Difficult to label, but there is something like values, personal identification with the issue!
2. Empathy.
4. As reported in the comments, I suggest: 1. Include surveillance as competence in the "Assessment" Domain. I consider surveillance crucial in public health and a very complex activity. Therefore invite you to think about the possibility of identifying a specific domain 2. Distinguish "Evaluation" as "practical evaluation" we have to conduct, as practitioners, from scientific evaluation, an activity carried out by experienced researchers. Therefore I suggest the separation of the 2 domains, or some other rearrangement 3. Training should be considered, in an existing domain (Communication?) or in a new domain.
5. Collaboration with other public health disciplines...health promotion should not exists (maybe even cannot exists) isolated.
6. But suggest combination of domains e.g. Assessment and Evaluation into Research.
7. The problem is that many of these areas/domains are so general that most of us agree with these/statements, but if we specify there will be so many different and (missing rest of text)
8. Merge Communication and Advocacy and include Social Marketing within this heading too as the competencies described could be said to describe those involved in Social Marketing.
9. We are faced with short finance, so this would be include in the same solution as for health services.
10. At the moment I’m not sure, it will be more clear after one round.
### Question 104. Domains

Are there any domains that you would like to see removed from the framework document?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
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<tbody>
<tr>
<td></td>
<td>14.3% (12)</td>
<td>85.7% (72)</td>
</tr>
</tbody>
</table>

**Comments**

1. Content of the domain 10 knowledge could be integrated into others.
2. Those related to a directive proceeding instead of leadership.
3. Evaluation and research.
4. Knowledge as stated above.
5. I am not sure. But, if the main aim of the document is addressing the competencies of practitioners, Research might be excluded as an autonomous domain.
6. This paper is very comprehensive and it is important to shorten some of the domains. Specially domains on leadership and management.
7. Not removed but renamed: communication AND social skills.
8. But all of them needs to be shortened and simplified avoiding duplicities as much as possible.
9. Catalyzing change and Implementation are also very comparable and interchangeable domains. The essence of implementation is to catalyze change!
10. Merging advocacy and communication would result in one less domain.
11. I think you can rework the domains; knowledge, advocacy, partnership and leadership. They cross each other.

### Question 105. All Competencies

Overall, I would rate the competency framework as:

<table>
<thead>
<tr>
<th>Very Poor</th>
<th>Poor</th>
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<td>4.40</td>
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</table>

**Comments**

1. It is too theoretical, too long and practical usage is questionable.
2. Some of the competencies are not specific to health promotion. I wonder if we can identify those.
3. But the framework seems to be more a list of domains and activities rather than a competency framework.
4. There is a need for intensive discussion what is really an important domain!
5. Maybe a bit too ambitious because who is really able to fulfill the requirements and cover the whole range of competencies to a certain extent?!
6. Many of the items are not to me competencies, but statements of tasks, roles etc. Many are lacking specification of the key skill set to achieve the statements.
7. Very comprehensive.
8. The competencies within the established domains are very much policy oriented and less practice oriented.
9. But too many elements, even they are all important.
10. Too comprehensive.
11. In all, your work with the core competences is a fantastic contribution to public health! Very well done!
12. I strongly agree in most of the points made in the CompHP CC but the difficulty is that there are so many points underneath every Domain. It would be interested to know what happened if you asked people to rank the points under domain 1 and so on.
13. This framework document is very comprehensive.
14. Competencies related to ‘knowledge’ and ‘enabling change’ differ in some way from the other domains that are identified.
15. There are too many and almost impossible to grasp.
### Question 106.

**All competencies**

The framework adequately reflects current health promotion practice

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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<td>26.7% (23)</td>
<td>3/79</td>
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</table>

**Comments**

1. It reflects more likely the HPP ‘to be’
2. Again the framework is too theoretical comparing to practice.
3. The professionals are far from this standards.
4. Reflects what we wish hp practice could be ideally. I do not think that it is true at the moment for most of our health promotion professionals
5. It misses the point of participation; it sounds far away.
6. I think there is a gap between theory and practice, at least from the German perspective. But we are heading the right direction as outlined in the health promotion competencies framework.
7. As they stand many encompass very wide ranging knowledge and skills, by implication, if not stated, probably way above some practitioner levels.
8. Very hard to say whether it does - my guess is that it SHOULD but probably doesn’t - yet!
9. It reflects ideal (or best) practice. We need look ahead.
10. Personnel from health promotion is not always legally and formal empowered to use all the competencies mentioned. These are the competencies that should be practiced rather buy leaders who are not part of the health promotion network.
11. Too comprehensive and reflects more than HP.
12. I think current HP practice is still largely health education and does not cover sectors beyond health sector.
13. Not in Austria.
14. Depends what do we consider health promotion practice; to me it does reflect health promotion research, but little health promotion practice at least in Denmark, where health promotion is often considered equal to disease prevention.
15. In some countries in the region of Central and Eastern Europe this framework is still vision more than everyday practice.
16. I have made reference to political awareness and understanding as well as outcomes focus as my experience has shown these to be cri
17. There is a huge difference between the theoretical framework and practice!
18. It reflects health promotion knowledge rather than health promotion practices.
19. I agree that it reflects practice as we would like it, however it would be untrue to say that health promotion practitioners in Ireland would currently all have the full set of competencies.
20. I do not have sufficient knowledge of current health promotion practice at ground level. The core competencies as set out set the bar extremely high. Many of these core competencies are learned from practical experience so they are competencies to be aimed for but could not possibly be present in all new practitioners.
21. It doesn't reflect in all countries.
22. I'm not sure - reflect practice - reality or pursuit.
**Question 107.**

**All Competencies**

This framework will be useful in developing workforce capacity for health promotion in Europe

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</tbody>
</table>

**Comments**

1. Very useful for specialists and advanced level but too high level for frontline provider.
2. The frame is not clear.
3. If it is widely accepted by researchers, scientists, lecturers and tutors (the whole academia), and practitioners (those who are working at the frontline) as well.
4. Needs to be clearer and more indication of the level expected included.
5. Yes will give coherence, visibility, accountability.
6. Has to be much more user friendly.
7. Depends on the final curriculum, the academic base etc.
8. Only if either Ministries of Health or employers see the value to their corporate objectives.
9. At least it can be useful in focusing what is needed to be successful.
10. Step by step up to the development and standards in the EU countries.
11. I do not see how; it is so abstract.
12. There is repetition for some of the health promotion actions through the different domains.
13. There are too many and maybe too ambitious.

**Question 108.**

**All Competencies**

This framework will assist in planning health promotion workforce capacity for the future

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Respondents</th>
<th>Mean</th>
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<td>41.9% (36)</td>
<td>4.20</td>
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</table>

**Comments**

1. It depends on the way in which state agencies and universities include the "core competencies" in the curriculum (in relation to the pre-service and in-service education of the professionals of the health, social, education sectors ...). The involvement of the different national networks could make a difference (at least in France).
2. See 107.
3. As above.
4. One of the most realistic domain.
5. It will be useful if including in advance multidisciplinary training programmes.
6. Will be very helpful tool for systematic planning, implementation of HP workforce in building capacity and new generations and sustainable quality of life in EU and Globally.
7. It is really not new; maybe for other people it is; there are instruments that describe the same items already.
### Question 109. All Competencies
**This framework adequately reflects the evidence base for good practice in health promotion**

<table>
<thead>
<tr>
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</table>

**Comments**

1. Did not have time to look at the evidence enough.
2. Too Anglo-Saxon.
3. But there has still a lot of work to be done.
4. There is a lack of evidence base for good practice in HP.
5. Research-practice & policy link is rather thinly covered.
6. There is not much evidence base.
7. Show us how to develop and use standards in HP, what can improve good practice.
8. I think the framework reflects best practice.
9. It lacks text about health equity.

### Question 110. All Competencies
**This framework adequately reflects the ethical dimensions of health promotion and their application in practice**

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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**Comments**

1. Ethical dimensions are not always clearly defined, and uniquely understood.
2. See comment on values, personal identification with the issue.
3. This is very welcome in order to avoid all kind of healthism and victim blaming or several attempts to put a duty to be and to stay healthy for all people on the political agenda.
4. The basic philosophical background is missing: utilitarian, libertarian, communitarian (or the Nuffield Council 'stewardship model' - this could lay the basis to understand approaches chosen or available in different contexts.
5. Up to various situation in the countries its echo of thinking models and actual health policy. The role of EU, WHO and IUHPE have chosen the right solution and way: HE and HP is the best solution for today.
6. Simplifies the content of the domains, or change the domains in order not to be repetitive throughout the different domains. For instance health inequalities.
**Question 111.**

*If you have any suggestions on how to improve the framework as a whole or specific competencies please give detailed feedback here.*

### Comments

1. It would be necessary to try to quote and or score the relevance of the domains and inside each one, the different items.
2. In my opinion it is a great compilation but it is not yet very helpful e.g. to make a capacity building plan.
3. I would suggest to shorten the list and to make competencies more specific.
4. I would suggest to: put all vision and targets into the introduction chapter and shorten the descriptions of the competencies; make a distinction between competencies and different to dos, tasks, targets, values and visions. -- distinguish between what health promoters need to do (targets, tasks, visions, processes) and what are the competencies/skills/knowledge/experience the need to have + what are the specific methods they should know; maybe it would be useful to mention that single health promoters should have some of the capacities (not all of them); it is not clear if the capacities are those of persons, teams or organisations; it would be nice to have a description about what are skills, capabilities, capacities, knowledge, experience etc; maybe a statement would be interesting about what are the core scientific disciplines of health promotion that contribute to hp capacities.
5. A Delphi questionnaire is a first step; but to reach a consensus there should be a more detailed and broad discussion of the health promoting community.
6. Well, the whole time while I was filling in the large questionnaire (it took me hours) I was thinking: Smaller would be beautiful! or: Less could be more! My recommendation would be: try to shorten and to focus on the really essential competencies which are necessary for a good health promotion practice.
7. Suggestions made along the way.
8. The current stage of the framework reflects a broad variety of competencies, partly overlapping. In a later stage of the process it might be useful to formulate specific profiles for special sectors of health promotion or different fields of practice.
9. Some competencies are overlapping with competencies in other domains. Several competencies could be formulated in a shorter form to make them more clear and understandable.
10. Look at the suggestions in the comments.
11. It would be useful to try to define each competency within the domains for those who will use the results of the project.
12. Going through the framework one could easily lose focus.
13. "Sustainability" might be a word to use in the description of interventions to choose.
15. This seems to work well with those who would identify themselves as health promoters, but is perhaps less useful in the context of the diverse ways that people promote health across Europe (particularly in the context of the health in all policies and SDH agenda).
16. The state of the art is that 1) HP is not exclusive for HP workers and 2) HP is more than the rational planning and evaluation of interventions. The challenge is to come up with a competence profile reflecting these two major changes. It is better to speak about the function of HP in stead of the professional HP.
18. Several of these domains need further and more deep discussion.
19. We strongly agree with the content of the document and core competencies since it reflects the Ottawa Charter. However, based on our experiences, there are some problematic areas that are not included in the present questionnaire. Creating and using indicators to monitor the implementation of short term, midterm and long term aims and of health promotion programmes should be also a core competence. Suggested indicators are both input, output and outcome indicators. Indicators are also needed to analyze the cost-effectiveness and cost-benefit of programmes. It should be also a core competency to be able to carry out cost-effectiveness and cost-benefit and cost-efficacy analysis of health promotion programmes. These would be needed both in the phase of project planning and project evaluation in order to prove effectiveness and benefits of the programmes in the long run. The lack of cost-effectiveness and cost-benefit analysis of health promotion programmes result in little possibility to enforce the interest of health promotion compared to other sectors. However, it is a real challenge to find the right indicators proving effectiveness in today’s fast changing world.
20. First time, I am involved in this research. My professional work has been connected with HE and HP. We were among the beginners, who started with HP in the country. The reason, why we start with NGO was, that HP wasn't yet developed. So with help of internal organizations, we got the opportunity to make us familiar with innovative approaches, strategies, new topics, methods. Organizing education for professionals in multi and trans sectors, in public health and education services, we presented new knowledge, of own experiences and activities at local, regional, national, international level. starting with Ottawa Charter and other documents. We are happy, that have had the privilege to work with many outstanding professional from
EU and world. So our duty is to share the knowledge, experiences and activities among people, different target groups, people: lay, professional, ill, handicapped, invalids. Just now, we are preparing workshops "Humour, smile promote health, self esteem, Sloven public event for healthy and cancer survivor. If you would like, you can everywhere find the place for doing and acting HP and HE. Our problem is, that after independence some programmes had not the priority, now we are faced with the efforts with new Health Minister, who's priority is HP and HCS in the policy. We need public health school, which could effective and efficient educate professionals for HP. After my opinion, HP will working the best, if all professional teams will participate in realizing the needed programme. This questionnaire is systematic guideline, how to do HP. My congratulations. It could be used in each country, institution, NGO. Shows us also in which direction we came go. This is the way, how to come to useful valid standards in HP. We learn from each other and contribute to the overall awareness of HP and overcome the poorness, protect right to health and common rights. Thank you for inviting us to be a part of this research. With Pleasure, we would do it again.

21. Many of described competences seem to be rather the result of applying knowledge and individual skills and not knowledge and skills that a promoter of health should have. Maybe the document should be organized into two sections for each area of competence: skills and knowledge.

22. I think that the core competencies are at high level; they should be common for experienced seniors and for persons being in charge of projects, programmes or health promotion organizations.

23. I agree with the statements expressed by the framework but have in same time the filling that it is written to ideally - only from the positive and supporting side.

24. The document should have a positive connotation but in same time it should be also realistic and giving the possibility to look at the dark side and problems appearing in health promotion practical application and in same time it should lead to elaboration of solutions for avoiding non-effective partnerships and programmes without evident success.

25. As I said earlier I do not have sufficient knowledge of current health promotion practice at ground level. The core competencies as set out set the bar extremely high. Many of these core competencies are learned from practical experience so they are competencies to be aimed for but could not possibly be present in all new practitioners. I would want to rely on those currently working as health promotion practitioners to say whether the core competencies are core from the beginning or what should be aspired to.

26. It is clear that flexibility within each of the domains is possible to emphasise certain competencies over others as per a particular area of work. Within each of the domains the number of competencies range from 6-10 and it may be necessary to stipulate that a certain number of competencies must be addressed within any domain in order to meet a particular level of competency.

27. At many places you write e.g. promote health and reduce health inequities”. Addressing health inequity requires certain interventions and you might need to separate these at some places. I wish you could address health inequity in a more clear way.

Demographics

Question 112. Please indicate which professional area you work in?

<table>
<thead>
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<th>Policy</th>
<th>Academia</th>
</tr>
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<td>30.6% (26)</td>
<td>43.5% (37)</td>
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</table>

Question 113. Please indicate your level of professional education

<table>
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<th>Postgraduate Diploma</th>
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<td>30.6% (26)</td>
<td>54.1% (46)</td>
<td>8.2% (7)</td>
</tr>
</tbody>
</table>

Question 114. Does the term 'Health Promotion' appear in your educational qualification?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>35.3% (30)</td>
<td>64.7% (55)</td>
</tr>
</tbody>
</table>
**Question 115.**

*How many years have you been working in the field of health promotion?*

<table>
<thead>
<tr>
<th>Years</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-5 Years</td>
<td>12.9%</td>
<td>11</td>
</tr>
<tr>
<td>5-10 Years</td>
<td>16.5%</td>
<td>14</td>
</tr>
<tr>
<td>10-15 Years</td>
<td>18.8%</td>
<td>16</td>
</tr>
<tr>
<td>15+ Years</td>
<td>45.9%</td>
<td>39</td>
</tr>
<tr>
<td>Other</td>
<td>5.9%</td>
<td>5</td>
</tr>
</tbody>
</table>

**Question 116.**

*Have you any previous experience of working with health promotion or public health competencies?*

<table>
<thead>
<tr>
<th>Experience</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>74.1%</td>
<td>63</td>
</tr>
<tr>
<td>No</td>
<td>25.9%</td>
<td>22</td>
</tr>
</tbody>
</table>

**Question 117.**

*What country are you representing?*

<table>
<thead>
<tr>
<th>Country</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portugal</td>
<td>4</td>
</tr>
<tr>
<td>Finland</td>
<td>3</td>
</tr>
<tr>
<td>Macedonia</td>
<td>3</td>
</tr>
<tr>
<td>Austria</td>
<td>4</td>
</tr>
<tr>
<td>Italy</td>
<td>3</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1</td>
</tr>
<tr>
<td>France</td>
<td>3</td>
</tr>
<tr>
<td>Hungary</td>
<td>2</td>
</tr>
<tr>
<td>Estonia</td>
<td>2</td>
</tr>
<tr>
<td>Germany</td>
<td>2</td>
</tr>
<tr>
<td>Lithuania</td>
<td>3</td>
</tr>
<tr>
<td>UK</td>
<td>3</td>
</tr>
<tr>
<td>Ireland</td>
<td>5</td>
</tr>
<tr>
<td>Greece</td>
<td>1</td>
</tr>
<tr>
<td>Croatia</td>
<td>3</td>
</tr>
<tr>
<td>Romania</td>
<td>3</td>
</tr>
<tr>
<td>Iceland</td>
<td>2</td>
</tr>
<tr>
<td>Spain</td>
<td>3</td>
</tr>
<tr>
<td>Denmark</td>
<td>2</td>
</tr>
<tr>
<td>Sweden</td>
<td>3</td>
</tr>
<tr>
<td>Netherlands</td>
<td>3</td>
</tr>
<tr>
<td>Czech Rep</td>
<td>1</td>
</tr>
<tr>
<td>Latvia</td>
<td>3</td>
</tr>
<tr>
<td>Norway</td>
<td>2</td>
</tr>
<tr>
<td>Malta</td>
<td>2</td>
</tr>
<tr>
<td>Slovenia</td>
<td>2</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Poland</td>
</tr>
<tr>
<td>---</td>
<td>---------</td>
</tr>
<tr>
<td>2</td>
<td>Cyprus</td>
</tr>
<tr>
<td>2</td>
<td>Belgium</td>
</tr>
<tr>
<td>Draft 2</td>
<td>Draft 3</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>1. Enabling Change</strong></td>
<td><strong>Enable Change</strong></td>
</tr>
<tr>
<td><strong>Enable change and empowering individuals and communities to improve their health</strong></td>
<td>Moved from 1 to 2 in order of presentation and Domain name changed to Enable Change</td>
</tr>
<tr>
<td>1.7 Enable individuals and communities to improve their health and reduce health inequities through undertaking a variety of health promotion activities including community development and empowerment strategies, advocacy and lobbying, organisational and environmental strategies, mass media strategies and health education</td>
<td>Enable individuals, communities and organisations to improve health and reduce health inequities through undertaking a variety of health promotion actions:</td>
</tr>
<tr>
<td>1.8 Contribute to building healthy public policy across all sectors and levels to ensure that health, economic and social policies lead to improved health and reduced health inequities</td>
<td>2.1 Work across sectors to ensure that all health, economic and social policies lead to improved health and reduced health inequities</td>
</tr>
<tr>
<td>1.9 Contribute to the creation of supportive environments to improve health and reduce health inequities using approaches such as the settings-based approach</td>
<td>2.2 Use a range of approaches such as the settings-based approach to create environments which support health</td>
</tr>
<tr>
<td>1.10 Strengthen community action by facilitating community participation and ownership through community development processes, and building capacity within communities for improving health based on mutual trust and respect</td>
<td>2.3 Facilitate community participation and ownership in health promotion actions through community development processes and building capacity within communities</td>
</tr>
<tr>
<td>1.11 Facilitate the development of personal skills by enabling individuals to make healthy choices and access the resources they require to improve health through health education and strategies that support personal change</td>
<td>2.4 Facilitate the development of personal skills to maintain and improve health using empowerment strategies</td>
</tr>
<tr>
<td>1.12 Contribute to the reorientation of the health services towards health promotion and reducing health inequities through the provision of information, expertise, collaboration and partnership</td>
<td>2.5 Work in collaboration with key stakeholders to reorient health services towards health promotion</td>
</tr>
<tr>
<td>2. Leadership</td>
<td>6. Leadership</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Contribute to the provision of strategic direction and opportunities for participation in developing healthy public policy, mobilising and managing resources for health promotion, supporting health promotion programmes and building capacity</strong></td>
<td><strong>Moved from 2 to 6 in order of presentation</strong>&lt;br&gt;Contribute to the development of a shared vision and strategic direction for health promotion actions:</td>
</tr>
<tr>
<td>2.10 Demonstrate democratic and empowerment leadership skills reflecting health promotion principles</td>
<td>6.1 Use democratic and empowerment leadership skills including active listening, negotiation, team work, motivation, conflict resolution, decision-making, facilitation and problem-solving skills</td>
</tr>
<tr>
<td>2.11 Contribute to the development of a vision and strategic direction for health promotion policies and programmes</td>
<td>6.2 Network with and motivate key stakeholders in relevant organisations, including one’s own, in leading change to promote health.</td>
</tr>
<tr>
<td>2.12 Work to influence one’s own and other organisations and key stakeholders to promote health and address health inequities</td>
<td>6.3 Reflect on learning and achievement needs at individual and organisational levels to build health promotion capacity</td>
</tr>
<tr>
<td>2.13 Demonstrate leadership in facilitating change through utilising interpersonal skills (negotiation, team work, motivation, conflict resolution, decision making, facilitation and problem solving skills) to promote health and reduce health inequities</td>
<td>6.4 Incorporate new knowledge and ideas to improve practice and respond to emerging challenges in health promotion</td>
</tr>
<tr>
<td>2.14 Build and maintain capacity in individuals, teams, groups and communities to support the development and implementation of sustainable health promotion policies and programmes</td>
<td>6.5 Mobilise and manage resources for health promotion actions</td>
</tr>
<tr>
<td>2.15 Mobilise and manage resources for effective and efficient health promotion programmes and policies</td>
<td></td>
</tr>
<tr>
<td>2.16 Contribute to the development and implementation of ethical and evidence-based policies, procedures, guidelines and protocols for health promotion</td>
<td></td>
</tr>
<tr>
<td>2.17 Synthesise new knowledge and processes into the development of health promotion policies and practice to improve health and reduce health inequities</td>
<td></td>
</tr>
<tr>
<td>2.18 Engage in reflective practice and take action to identify and meet learning and development needs at individual and organisational levels</td>
<td></td>
</tr>
<tr>
<td>3. Assessment</td>
<td>7. Assessment</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------</td>
</tr>
<tr>
<td><strong>Conducting assessment of needs and assets in settings and systems that lead to the identification and analysis of the behavioural, cultural, social, environmental, organisational and political determinants that promote or compromise health</strong></td>
<td><strong>Moved from 3 to 7 in order of presentation</strong></td>
</tr>
<tr>
<td>4.10 Collect, review and critically appraise relevant data, information and literature for health promotion policies and programmes from primary and secondary sources using a variety of methods including social sciences and epidemiological methods</td>
<td><strong>7.1 Identify priorities for health promotion actions in consultation and partnership with key stakeholders, using available evidence and health promotion principles</strong></td>
</tr>
<tr>
<td>4.11 Identify and involve community members and other stakeholders in health promotion assessment processes</td>
<td><strong>7.2 Collect, review and critically appraise relevant data, information and literature</strong></td>
</tr>
<tr>
<td>4.12 Identify, adapt and apply culturally relevant and appropriate health promotion assessment approaches for people from diverse cultural, socioeconomic and educational backgrounds and of all ages, genders, health status, abilities and sexual orientation</td>
<td><strong>7.3 Use a variety of assessment techniques including quantitative and qualitative research methods</strong></td>
</tr>
<tr>
<td>4.13 Identify existing assets and resources at all levels in organisations and communities which can support action on health promotion to improve health and reduce health inequities</td>
<td><strong>7.4 Engage stakeholders in the assessment process</strong></td>
</tr>
<tr>
<td>4.14 Identify the environmental, social, cultural, organisational, behavioural and biological factors which may act as barriers to, or drivers for health promotion action</td>
<td><strong>7.5 Use culturally appropriate assessment approaches</strong></td>
</tr>
<tr>
<td>4.15 Assist populations, communities and groups to articulate their experiences of health needs and to identify capacities for health promotion action</td>
<td><strong>7.6 Identify existing assets and resources in individuals, organisations and communities</strong></td>
</tr>
<tr>
<td><strong>4.16 Identify priorities for health promotion interventions based on consultation and in partnership with key stakeholders, available evidence and health promotion principles</strong></td>
<td><strong>7.7 Identify political, economic, social, cultural, environmental, behavioural and biological determinants which impact on health</strong></td>
</tr>
<tr>
<td>-------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Developing measurable health promotion 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</td>
<td>Moved from 4 to 8 in order of presentation</td>
</tr>
<tr>
<td>5.1 Develop comprehensive and sequential intervention plans based on an appropriate assessment of needs and assets, theory and available evidence of effective health promotion practice</td>
<td>Develop measurable health promotion goals and objectives in response to assessment of needs and assets and identify strategies that are based on knowledge derived from theory, evidence, practice and consultation with stakeholders:</td>
</tr>
<tr>
<td>5.2 Review health promotion approaches, methods and plans for their acceptability to diverse population groups</td>
<td>8.1 Use a systematic approach to health promotion action planning</td>
</tr>
<tr>
<td>5.3 Identify an appropriate mix of strategies to achieve objectives based on consultation with stakeholders and available evidence of effective health promotion interventions</td>
<td>8.2 Develop and communicate appropriate, realistic and measurable goals and objectives</td>
</tr>
<tr>
<td>5.4 Formulate and communicate appropriate, realistic and measurable goals and objectives for health promotion interventions</td>
<td>8.3 Identify an appropriate mix of strategies to achieve objectives</td>
</tr>
<tr>
<td>5.5 Identify the resources (skills, personnel, partner contributions, finance, materials, training and support) available and those required to develop, implement and evaluate sustainable health promotion interventions</td>
<td>8.4 Identify and secure resources (skills, personnel, partner contributions, finance, materials, training and support) for sustainable health promotion action</td>
</tr>
<tr>
<td>5.6 Develop a feasible action plan and an adequate budget to implement effective health promotion interventions</td>
<td>8.5 Develop a feasible action plan within resource constraints and with reference to existing needs and assets</td>
</tr>
<tr>
<td>5.7 Mobilise support and engage the participation of key stakeholders in health promotion programme and policy development, planning and implementation</td>
<td>8.6 Mobilise, support and engage the participation of key stakeholders</td>
</tr>
<tr>
<td>5.8 Develop evaluation plans to assess the process, impact and outcomes of interventions based on health promotion principles and in consultation with key stakeholders</td>
<td></td>
</tr>
<tr>
<td>5.9 Develop effective feedback mechanisms as part of process evaluation to ensure that health promotion interventions are being implemented as intended and that contingency plans for programme improvement are in place</td>
<td></td>
</tr>
<tr>
<td>5. Implementation</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Carrying out effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources</strong></td>
<td></td>
</tr>
<tr>
<td>5.8 Use culturally relevant and appropriate health promotion approaches for diverse cultural, socioeconomic and educational groups, and persons of all ages, genders, sexual orientation, ethnicity, health status and abilities</td>
<td></td>
</tr>
<tr>
<td>5.9 Develop, pilot and use appropriate health promotion programme resources and materials in collaboration with stakeholder groups</td>
<td></td>
</tr>
<tr>
<td>5.10 Implement health promotion strategies using ethical, empowering and participatory processes appropriate to specific contexts</td>
<td></td>
</tr>
<tr>
<td>5.11 Ensure that the quality of implementation of health promotion programmes is monitored and meets agreed goals and objectives</td>
<td></td>
</tr>
<tr>
<td>5.12 Use feedback from process evaluation to maintain and improve the effective implementation of planned health promotion interventions</td>
<td></td>
</tr>
<tr>
<td>5.13 Manage resources, including the necessary staffing, skills and budgets needed for the effective implementation of health promotion interventions</td>
<td></td>
</tr>
<tr>
<td>5.14 Facilitate programme ownership and sustainability of effective health promotion interventions through ongoing consultation and collaboration with key stakeholders</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moved from 5 to 9 in order of presentation</strong></td>
</tr>
<tr>
<td><strong>Implement effective and efficient, culturally sensitive, and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources:</strong></td>
</tr>
<tr>
<td>9.1 Use culturally relevant and appropriate health promotion implementation approaches</td>
</tr>
<tr>
<td>9.2 Use ethical, empowering and participatory processes appropriate to specific contexts</td>
</tr>
<tr>
<td>9.3 Develop, pilot and use appropriate programme resources and materials</td>
</tr>
<tr>
<td>9.4 Monitor the quality of implementation of programmes in relation to agreed goals and objectives</td>
</tr>
<tr>
<td>9.5 Use process evaluation feedback to maintain and improve effective implementation</td>
</tr>
<tr>
<td>9.6 Manage the resources needed for effective implementation</td>
</tr>
<tr>
<td>9.7 Facilitate programme sustainability and stakeholder ownership through ongoing consultation and collaboration</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>6.10 Incorporate evaluation into the planning and implementation of all health promotion activities</td>
</tr>
<tr>
<td>6.11 Identify the need for, and engage with technical and research expertise as required to develop and apply research methods for monitoring and evaluation</td>
</tr>
<tr>
<td>6.12 Use appropriate health promotion evaluation and monitoring methods incorporating process, impact and outcome measurement, in partnership with stakeholders</td>
</tr>
<tr>
<td>6.13 Apply evaluation findings to refine and improve health promotion interventions and support the sustainability and dissemination of effective practice</td>
</tr>
<tr>
<td>6.14 Communicate clearly evaluation findings to diverse stakeholder groups</td>
</tr>
<tr>
<td>6.15 Critically consider the practice and policy implications of findings from the monitoring and evaluation of health promotion activities</td>
</tr>
<tr>
<td>6.16 Contribute to the advancement of health promotion knowledge and practice through the use of research and evidence-based strategies</td>
</tr>
<tr>
<td>6.17 Contribute to planning, conducting and writing health promotion evaluation initiatives and preparing research proposals for funding</td>
</tr>
<tr>
<td>Review and disseminate relevant health promotion research and literature</td>
</tr>
<tr>
<td>7. Advocacy</td>
</tr>
<tr>
<td>-------------</td>
</tr>
<tr>
<td>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</td>
</tr>
<tr>
<td>7.12 Identify and create opportunities to advocate for and with individuals, groups, communities and organisations to improve their health and address health inequities</td>
</tr>
<tr>
<td>7.13 Identify strategic alliances and mechanisms for advancing health promotion policy and practice</td>
</tr>
<tr>
<td>7.14 Identify critiques of health promotion and develop strategies to respond to them</td>
</tr>
<tr>
<td>7.15 Develop, implement and evaluate advocacy plans for health promotion using a range of advocacy strategies and techniques</td>
</tr>
<tr>
<td>7.16 Raise awareness and influence public opinion on health promotion by identifying and accessing relevant media and disseminating a range of resources and information</td>
</tr>
<tr>
<td>7.17 Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non-governmental organisations) on the development and implementation of health promotion policies and programmes</td>
</tr>
<tr>
<td>7.18 Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers</td>
</tr>
<tr>
<td>7.19 Enable and support communities in the articulation of their views and concerns about health and health inequities</td>
</tr>
<tr>
<td>7.20 Contribute to influencing and shaping organisational, multiagency, regional and national agencies to maximise opportunities for health promotion and reduce health inequities</td>
</tr>
<tr>
<td>7.21 Advocate for the development of policies, guidelines and procedures which impact favourably on health and reduce health inequities and provide health promotion input into their development</td>
</tr>
<tr>
<td>8. Partnership</td>
</tr>
<tr>
<td>----------------</td>
</tr>
<tr>
<td>Work collaboratively across disciplines, sectors, and partners to enhance the impact and sustainability of health promotion programmes and policies</td>
</tr>
<tr>
<td>8.7 Identify partners within and outside the health sector with the potential to support the development and implementation of health promotion policies and programmes</td>
</tr>
<tr>
<td>8.8 Facilitate intersectoral collaboration and build partnerships for health promotion using leadership, team building, negotiation and conflict resolution skills</td>
</tr>
<tr>
<td>8.9 Establish and maintain effective partnership working with key health promotion stakeholders, including, statutory bodies, community groups and voluntary/non-governmental organisations</td>
</tr>
<tr>
<td>8.10 Develop and sustain local, regional and national coalitions and networks for advancing intersectoral health promotion policies and programmes</td>
</tr>
<tr>
<td>8.11 Mediate between different sectoral interests and manage the partnership process in the development and implementation of health promotion policies and programmes</td>
</tr>
<tr>
<td>8.12 Review the effectiveness of partnerships and collaborative working for health promotion and make recommendations for improvements</td>
</tr>
<tr>
<td>9. Communication</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td><strong>11. Communication</strong></td>
</tr>
<tr>
<td><em>Communicating health promotion activities and programmes effectively using appropriate methods for diverse audiences</em></td>
</tr>
<tr>
<td>9.8 Communicate and disseminate data and information on health promotion policies and programmes to a range of diverse audiences</td>
</tr>
<tr>
<td>9.9 Use the media, advanced technologies and relevant networks to receive and communicate information on health promotion</td>
</tr>
<tr>
<td>9.10 Develop and disseminate written, oral and electronic communication (including reports, presentations and focused messages) on health promotion policies and programmes tailored to specific contexts</td>
</tr>
<tr>
<td>9.11 Use effective and culturally appropriate health promotion communication methods, techniques and language suitable for specific population groups</td>
</tr>
<tr>
<td>9.12 Apply interpersonal communication and groupwork skills to facilitate individuals, groups and communities to increase control over their health and reduce health inequities</td>
</tr>
<tr>
<td>9.13 Apply a range of communication skills to facilitate the development of personal skills and community action to improve health and reduce health inequities</td>
</tr>
<tr>
<td>9.14 Promote and debate the merits of diverse health promotion strategies using ethical, theoretical and evidence-based arguments</td>
</tr>
<tr>
<td>10. Knowledge</td>
</tr>
<tr>
<td>---------------</td>
</tr>
<tr>
<td>Demonstrate understanding of, and the ability to apply in practice, the theory, research and ethical dimensions of health promotion and the multidisciplinary knowledge base which underpins the competencies listed above</td>
</tr>
<tr>
<td>12.1 Demonstrate knowledge of the history and development of health promotion internationally including the Ottawa Charter (WHO, 1986) and successive charters and declarations as the foundations for health promotion practice</td>
</tr>
<tr>
<td>12.2 Demonstrate understanding of the core concepts and principles of health promotion and their application in practice</td>
</tr>
<tr>
<td>12.3 Demonstrate understanding of the concepts of health inequalities and inequities, their impact on health status and their relevance for health promotion policies and programmes</td>
</tr>
<tr>
<td>12.4 Demonstrate understanding of the theories, research and multidisciplinary knowledge base underpinning health promotion and their application in the development and implementation of health promotion practice, policy and research</td>
</tr>
<tr>
<td>12.5 Demonstrate knowledge and understanding of the ethical dimensions of health promotion and their application in practice</td>
</tr>
<tr>
<td>12.6 Demonstrate understanding of the importance of context for practice based on the socio-ecological model of health promotion</td>
</tr>
<tr>
<td>12.7 Demonstrate knowledge of the social, environmental, behavioural and biological determinants of health and their implications for the development of effective health promotion policies and programmes</td>
</tr>
<tr>
<td>12.8 Demonstrate awareness and knowledge of the impact of local, national, regional and international health systems, policies and priorities and their impact on health promotion practice</td>
</tr>
<tr>
<td>12.9 Demonstrate knowledge of, and sensitivity to, social and cultural diversity in all aspects of health promotion practice</td>
</tr>
</tbody>
</table>
Table 9: Results from Delphi Round 2

**Question 1. Domain 1. Knowledge**

Demonstrate understanding of, and the ability to apply in practice, the theory, research, values and multidisciplinary knowledge base of health promotion which underpins the competencies including:

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6% (1)</td>
<td>1.6% (1)</td>
<td>3.3% (2)</td>
<td>29.5% (18)</td>
<td>63.9% (39)</td>
<td>4.52</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. Knowledge domain should include the evidence of action which brings about change, and of community participation.
2. A particular knowledge is part of every single competency according to all (including your) definitions, so it should either be spelled out separately for every single competency or just left out (the same way as skills are left out as being an integral part of competencies). Furthermore, "the ability to apply knowledge base in practice" counts as skills, so this is tautology.
3. 'Knowledge' should not be a separate domain; each area of skill or competence requires underpinning knowledge.
4. Although separating out knowledge from action seems simpler in defining competence statements, the importance of being able to demonstrate action underpinned by knowledge and understanding cannot be overstated. In the PH practitioner standards the UKPHR has tried to phrase standard statements which combine both knows and shows, so that individuals must always demonstrate action and the underpinning knowledge and understanding that led to that action.
5. I don’t understand this sentence.
6. This domain should also include people’s right to health.

**Question 2. Competency 1.1**

The history and development of health promotion internationally, including the Ottawa Charter (WHO, 1986) and successive charters and declarations.

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6% (1)</td>
<td>1.6% (1)</td>
<td>6.6% (4)</td>
<td>41.0% (25)</td>
<td>49.2% (30)</td>
<td>4.34</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. Ottawa Charter has not lost timeliness, policies contradicting to this document proved to be less successful.
2. This is not competency, this is part of it: knowledge. As knowledge, it is core but one can be perfectly knowledgeable in the Ottawa Charter and still be a ruthless authoritarian in practice.
3. Though useful to understand the changing vision of health promotion and appreciate the solid history of profession, exact details of the charters and the declarations may not be essential.
4. I am not convinced that all HP practitioners need to be aware of the history of HP - rather that they should be encouraged to look forwards.
5. It is good to know but not that important.
6. Need to make clear links between this competency and number 1.7 so the local application of 1.1 is clearly understood.
Question 3. Competency 1.2
The core concepts and principles of health promotion and their application in practice
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>4.62</td>
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</tbody>
</table>

Comments
1. Culturally sensitive in application in practice I would say.
2. See my comment above. This is core knowledge, necessary but not sufficient to comprise core competency.
3. What core concepts and principles do you mean? Make it clearer so there can be no misunderstanding about it.
4. Agree with competency but would like to see reference to which set of core concepts and which set of principles are to be used as the standard.

Question 4. Competency 1.3
The concepts of equity and social justice, their impact on health status and relevance for health promotion.
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</tbody>
</table>

Comments
1. See my comment above. This is core knowledge, necessary but not sufficient to comprise core competency.
2. More and more social organisation is a central aspect for health and relevant in health promotion practice.
3. This could also be included under 1.2 or added to 1.2 (e.g. with emphasis on equity).
4. Relationship of social justice (which is undefined here) to health status is unclear.
5. While I agree with this competency it needs the addition of the 'right to health' to be complete
   A very good description of "Health as a Human Right" can be found on page 29 - Triggering Debate - White Paper The Food System. Health promotion Switzerland.

Question 5. Competency 1.4
The theories and research underpinning health promotion and their application in practice
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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</thead>
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<td>39.3% (24)</td>
<td>50.8% (31)</td>
<td>4.36</td>
<td>61</td>
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</tbody>
</table>

Comments
1. The same above refers to theory and practice.
2. This statement is so wide that it cannot be defined as core.
Question 6. Competency 1.5
The socio-ecological model of health (social, environmental, behavioural and biological determinants) as the basis for health promotion and its implications for practice
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tbody>
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<td>36.1% (22)</td>
<td>55.7% (34)</td>
<td>4.43</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments
1. I am not sure how this model can be efficient without introducing the socio-cultural activity approach to health.
2. Core knowledge, but not core competency.
3. But the central intervention must be made in a community based participatory research.
4. But mind and spiritual dimension has important influence too, also culture, condition and tradition, religion and new approaches of young generations.
5. Also cultural aspects and how to manage with economical demands.
6. Does the term ‘socio-ecological model’ presuppose a specific way of looking at health? If so, then perhaps the competency should be worded more broadly to encompass other models. Alternatively, this statement may already be covered by the language in 1.2 and 1.4.
7. Throughout this document a variety of terms is used to describe determinants and this is a bit confusing - e.g. see 47 Assessment Domain This domain uses a different list of determinants.

Question 7. Competency 1.6
The impact of local, national, regional and international health systems, policies and priorities and their relevance for health promotion actions.
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
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<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>39.3% (24)</td>
<td>4.15</td>
<td>61</td>
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</tbody>
</table>

Comments
1. Developing links and networks between the local, national, regional and other systems.
2. Too widely defined knowledge. E.g. at the international level does it include the WHO with all six regional offices, WB, ECDC, CDC regardless of where you work? WHO policies and priorities could be core, others not.
3. This competency is relevant for policy/decision makers in the field of health promotion, not for daily HP practitioners.
4. Very important to take a regional, national and international perspective as there will be different and sometimes competing drivers.
5. Again may be too big an ‘ask’ to have knowledge of all policies and priorities covering local to international – but important to know impact of policies that impact on own area of work. What may need to be included here though is reference to relevant legislation and governance systems as well as on policies.
6. Practitioners would certainly need to be aware of health systems, policies, etc. within their respective jurisdictions. The extent to which they would require a working knowledge of international health systems, policies and priorities is less clear.
7. The criteria is practically impossible to fulfil.
8. But this belongs to another competence. It is more a skill than knowledge.
### Question 8. Competency 1.7

**The implications of social and cultural diversity in all aspects of health promotion**

Do you agree this competency is core to health promotion practice?

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<th>Disagree</th>
<th>Uncertain</th>
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<td></td>
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<td>52.5% (32)</td>
<td>4.34</td>
<td>61</td>
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</table>

**Comments**

1. 1.5-1.7 are important but we need to include a sound knowledge of Political awareness and the vital contribution area such as Education make to the health promoting agenda.
2. And the professional sensitivity towards these diversities, to be recognized as ..resources rather than obstacles to health.
3. This statement is so wide that it cannot be defined as core.
4. A knowledge of the implications cultural and social diversity should be interwoven across all relevant HP standards.
5. Not sure 'in all aspects' - would certainly agree 'in own area of work'.
6. Tacit knowledge?
7. These implications are very important. The uncertainty is because of as fact that "cultural specificity" is often (in may regions/countries) used as justification of widespread stigma, prejudices, intolerance, harmful practices, etc.
8. We think that this has do with health inequities (1.3).
9. The criteria is practically impossible to fulfil.
10. Should also include reference to the unique needs and values of indigenous peoples. These people tend to have the most compromised health status in most countries and need a special focus if their health is to be improved to an acceptable standard.

### Question 9.

**Do you think there are any other competencies that should be included in the core domain Knowledge?**

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</table>

**Comments**

1. Knowledge of the basics of ethics and values.
2. Action competence – consisting of knowledge, commitment, vision, experience of action, and continual learning from it.
3. Explanation on health in all policies and how this has been extracted from healthy public policies. Global challenges and their interlink with local community actions.
4. Communication, coalitions, effectiveness methodology, evidence base dissemination, involvement of people and their participation since the beginning of the processes of HP.
5. If all there are also applied in practice, I think we can wait also results. Good basis.
6. There is core knowledge in every single core competency, e.g. Communication: e.g. basics of verbal and non-verbal communication, assessment and evaluation: knowledge of biostatistics etc. Knowledge CANNOT be a separate competency among others it is part of each competency.
7. The implications of gender inequalities in health promotion.
8. Understanding of basic ethical principles of health promotion.
**Question 10. Domain 2. Enable Change**

Enable individuals, communities and organisations to improve health and reduce health inequities through undertaking a variety of health promotion actions

Do you agree this domain is core to health promotion practice?

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>4.60</td>
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</tbody>
</table>

Comments

1. Specificities of working with special groups.
2. Enabling organisations to improve health and reduce health inequities is top-level advanced competency, not core.
3. It is important but change may not be the most important outcome from a HP activity.
4. Adapted to the needs, new era and generations and fast changes in the global world and society, science.
5. Methods should be bottom up and it is important that no one will be stigmatized.
6. Note that document uses both 'health promotion action' e.g. 3.3 and "health promotion actions" Personally prefer action as this implies dynamic and ongoing action.

**Question 11. Competency 2.1**

Work across sectors to ensure that all health, economic and social policies lead to improved health and reduced health inequities

Do you agree this competency is core to health promotion practice?

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>36.7 (22)</td>
<td>55.% (33)</td>
<td>4.38</td>
<td>61</td>
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</tbody>
</table>

Comments

1. I would add environmental policies.
2. Need to include Education and Culture explicitly.
3. Education and civil rights sector as well need to be included in the inter-sector collaboration.
4. This cannot be core as many HP practitioners simply are not in a position to initiate and/or implement intersectoral work.
5. Disagree with the formulation of this competency not with the competency itself. I think that “work across sectors” is fine, but not “to ensure” that all policies lead to improved health and reduced health inequalities. It is TOO ambitious as we know that there still are any unintended consequences of the policies and it is irrelevant to expect HP practitioners “to ensure” something. I think that “to observe” or just to work across sectors with the aim to get “health to all policies” is enough.
6. We are centred to optimal global change now in the given conditions, don’t forget the beautiful treasure of past experiences and guard this specialities, what shows us the way to HP and HE and NPH.
7. It is too ambitious and non realistic and out of power of HP practitioners: " all policies lead to improve health".
8. Would query the word ‘all’ - rather a tall order?
10. Improved and reduced imply past tense, but we are working to improve and reduce health inequalities in the present tense and future In NZ we have moved to the terms "health improvement" and "address inequities".
Question 12. Competency 2.2
Use a range of approaches such as the settings-based approach to create environments which support health
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>55.0% (33)</td>
<td>4.45</td>
<td>61</td>
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</tbody>
</table>

Comments
1. Culture-based, I would say, refer to more comprehensive framework for creating sustainable health promoting.
2. Core but other approaches should also be specified if the statement includes 'a range of approaches'.
3. An understanding of the different approaches is important but whether there would be sufficient opportunity to apply them is more questionable.
4. More support and start to work at LC.
5. Too vague; what is the range, what are the approaches?
6. Uncomfortable with any one approach identified the settings approach has been around since 1988 and is unlikely to be in vogue as long as these competencies are designed to last.
7. A human rights approach and/or determinants approach is more in keeping with trends.

Question 13. Competency 2.3
Facilitate community participation and ownership in health promotion actions through community development processes and building capacity within communities
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>4.65</td>
<td>61</td>
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</tbody>
</table>

Comments
1. Particularly children and youth communities participation.
2. At an individual and community level.
3. Again important to understand the potential impact by may not be able to implement.
4. Use also citizens and civil society -NGO’s initiatives.
5. May not apply to all HP practitioners unless the term ‘community’ can be interpreted widely.
6. How does ‘community development’ differ from building capacity within communities?
7. Core competencies can not be politically oriented and practically oriented at the same time.
Question 14. Competency 2.4

The development of personal skills to maintain and improve health using empowerment strategies

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>53.32% (32)</td>
<td>4.45</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments

1. It is under question for how long personal skills can maintain and improve health in for example, crisis situation.
2. Without a environmental involvement, this competence might be weak.
3. Competencies & 2.4 are very closely related.
4. Activities to develop personal skills are important, but should be supported by an environmental and setting approach. The effects of individual training as a single activity are limited.
5. Consider deleting 'using empowerment strategies' from this competency statement as meaning is not clear.
6. While I agree with this competency have concerns that "development of personal skills" is often simplified to only a health education approach.

Question 15. Competency 2.5

Work in collaboration with key stakeholders to reorient health services towards health promotion

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>4.42</td>
<td></td>
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</tbody>
</table>

Comments

1. Stakeholders need to be educated before the collaboration take step. All these components of enabling change are not (txt missing from pdf).
2. Health services are not orient to health promotion.
3. This cannot be core as many HP practitioners do not work in the health services and have no influence over health.
4. I think that it would be better to reformulate this competency and simply to say that "in collaboration with key stakeholders to include health promotion to health services". Currently (in the near future) an effort to reorient health services to "whatever" is naive and unrealistic.
5. I would say that it is better to reformulate this competency and simply say that "Include in collaboration with key stakeholders health promotion to health services". An effort to reorient health services towards "whatever” is currently naive and unrealistic.
6. But in a strong relationship with community stakeholders.
7. I think that not only health services, but all services should be reoriented towards HP.
8. Involvement by people is most important.
9. Agree but not all HP staff work in jobs that link to H Services. What if they work in an employment support/poverty type project? This may be less relevant or possible.
10. How the key stakeholders and the extent of collaboration required are defined? There is also a legacy problem in this thinking: health promotion is seen as a part of/opposed to health services, which is contradictory to the politics approach (policy change versus change of services etc.).
**Question 16.**
Do you think there are any other competencies that should be included in the core domain Enable Change?

<table>
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<tr>
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<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td></td>
<td>16.9% (10)</td>
<td>83.1% (49)</td>
</tr>
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</table>

**Comments**
1. Planning, organizing, leadership, vision. I see some are separated as particular domains, but I think they should be seen as inherited in more competencies, such as enabling change, assessment, (txt missing from pdf).
2. I am not sure.
3. To support environmental policies to make change easier.
4. It’s very important to collaborate widely and get individuals and communities to participate in action.
5. Enabling change requires advanced communication skills and advanced understanding of human psychology.
6. Understand local health, education, economic and community development systems.
7. The competencies are very comprehensive. Could they be more precise?
8. Demonstrate an understanding of, and empathy with, the influences on individual and community health, in my opinion, training adult people is a potent tool for enabling change (look at point 9 comment).
9. Don’t forget people’s initiatives and contribution of lay volunteers, NGO’s, public.

**Question 17. Domain 3. Advocacy**
Advocate with, and on behalf, of individuals, communities and organisations to improve health and well-being and build capacity for undertaking health promotion action

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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<th>Strongly Agree</th>
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<td>4.57</td>
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</table>

**Comments**
1. Advocating on behalf of organisations requires a certain position or authority which not all HP workers hold.
2. End this competency at the term "well-being". The "build capacity for undertaking health promotion actions" is more relevant to the 'enabling change' category.
3. Building capacity to improve health is the goal of health promotion - the goal is not to undertake more and more health promotion actions (e.g. increase bureaucracy & influence of political health promotion). Or at least one could hope so.
4. Suggest changing the domain description to be more consistent with other suggest "... to improve health and address inequalities to build capacity".

**Question 18. Competency 3.1**
Use a range of advocacy strategies and techniques that reflect health promotion principles

Do you agree this competency is core to health promotion practice?

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<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
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<td>4.43</td>
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</tr>
</tbody>
</table>

**Comments**
1. Mostly choosing health promotion best practices and developing research processes that enhance health and economic gains in health promotion.
2. Range must be defined in order to this criteria to be meaningful at all.
3. But you have to be clear which health promotion principle you mean.
**Question 19. Competency 3.2**

*Identify and create opportunities for advocacy on health promotion actions*

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>53.3% (32)</td>
<td>4.38</td>
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</table>

**Comments**

1. Creating opportunities is already advocacy, does not need to be separated from 3.1.
2. It is important, but it is not core.
3. Isn't it the same as 3.1?
4. I do not understand the meaning of this sentence ("advocacy on health promotion actions").
5. This appears to be part of 3.1.
6. This is unclear.
7. Some practitioners are better able to do this than others due to the nature of their jobs.
8. This competency can be difficult to achieve in some work situations where organisation policy doesn't allow advocacy.

**Question 20. Competency 3.3**

*Facilitate communities and groups to articulate their experiences of health needs and to identify capacities for health promotion action*

Do you agree this competency is core to health promotion practice?

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<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>53.3% (32)</td>
<td>4.43</td>
<td>61</td>
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</tbody>
</table>

**Comments**

1. This needs to be inclusive of what some might consider non health specific issues e.g. Finance.
2. Two distinct areas of competence.
3. Is this covered by 3.1?
4. I agree, but in this case as in other cases, I think that this competency can be core or not depending on the position of the HP practitioners.
**Question 21. Competency 3.4**

**Raise awareness and influence public opinion on health issues by identifying and accessing relevant media and disseminating a range of resources and information**

Do you agree this competency is core to health promotion practice?

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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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</table>

**Comments**

1. A note of caution here in that for many staff employed by or funded by the statutory sector such as a health system or local municipality they may have to comply with policies which restrict direct access with the media.
2. Isn't it just a subcategory of 3.1?
3. Also access to webpages, use internet based technology.
4. Using mass media for influencing public opinion is not a core competency as it requires advanced knowledge and media communication skills, not to mention a certain position - or would you count leaking and whistle blowing as HP activities?
5. It belongs to the "Communication Domain".
6. Would like to delete all after 'issues'
7. This maybe more of a communications or PR role.
8. Invite journalists, managements research institutions, opinion makers which build and “clarify” public opinion.
9. Awareness should be raised in own living environment.
10. Again am aware that some employment circumstances make it hard to achieve this competency.

**Question 22. Competency 3.5**

**Engage with key decision-makers (including local authority, government agencies and officials, community leaders and non-governmental organisations) to advocate for health promotion action**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>4.52</td>
<td>61</td>
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</tbody>
</table>

**Comments**

1. Prefer the word 'Enlist' to 'engage' as slightly more action-oriented.
2. Not clear whether there would be the opportunity for this thinking about from my country’s context there is not really any opportunity for a local community worker to engage with government agencies – so it would only apply to more senior management roles.
3. That competence is rather for mangers in HP.
4. Very similar to earlier section on collaborative working.
5. Unclear (including... and who else?).
Question 23. Competency 3.6
Participate in lobbying processes for health promotion including making oral and written submissions, preparing and circulating petitions and position papers
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>3.97</td>
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</tbody>
</table>

Comments

1. Please see comments in 3.6 above as the principle also applies here.
2. Some people are better at this than others.
3. I consider it more political than technical (scientific).
4. This competency is useless. I consider it too political, not ‘scientific’.
5. Don’t go for the idea of petitions, not part of contemporary HP practice.
6. The political situation in a given region or country make this result uncertain.
7. This would only be appropriate for more senior roles using new technology, nanotechnology, electronic machines, actual new adds of communications, promotion and advertising, blogs in positive way.
8. Rather for managers.
9. The word lobbying can have a particular political meaning in the and I would not see political lobbying as a core competence of a professional HP worker.
10. In my country I employed by the crown we are not allowed to engage in lobbying processes in any form (but we find ways around it) - I wonder if this is reflected in some European countries and if so is there another less obvious word that could be used. Re making submissions with increasing use of electronic media it is no longer sufficient to identify only oral and written submissions. Prefer the terms of “formal and informal submissions” However there are many more forms of lobbying, and I wonder the rationale for identifying just submissions, petitions and papers? (I find petitions to have limited value and don’t consider them a key tool) I suggest that the competency should be left generalised to allow for developments and changing trends (especially via electronic media) during the life of these competencies.

Question 24. Competency 3.7
Advocate for the development of policies, guidelines and procedures which impact positively on health and reduce health inequities
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>55.0% (33)</td>
<td>4.43</td>
<td>61</td>
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</tbody>
</table>

Comments

1. It is important, but not core. And - in reality - it takes a lot of time.
2. Developing policies and guidelines cannot be a core HP competency.
3. As above.
4. This is effectively 3.6 without the politics.
5. Too demanding.
6. Again suggest that reducing health inequities can still leave a large gap this is not enough we need to "address inequities"
**Question 25.**
*Do you think there are any other competencies that should be included in the core domain Advocacy?*

<table>
<thead>
<tr>
<th>Yes</th>
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<tbody>
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</table>

**Comments**

1. Health promotion staff at all levels need to clearly understand what advocacy really means as a concept within their own working environment, for some this will mean acting as 'indirect' advocates by building the capacity of others such as community groups while on other occasions they will be 'direct' advocates within their work system.
2. However, I do not see these only as competencies, but rather components of the unique body of the advocacy, which refer to the tools/instruments, resources, target groups/populations aims etc.
3. I am not sure.
4. To work with mass media professionals.
5. Understand basic principles of policy development and drafting policy documents.
6. Demonstrate an understanding of, and empathy with, principles of equity and social justice.
7. Reduce large possibility of attacks on special groups [vulnerable, marginalised etc] in sense to show them, how strengthen themselves and choose to help them make the right decisions.
8. Health promoters should be under evaluation: we believe that we are doing good but never understand what kind of harm our work could cause in some circumstances.

**Question 26. Domain 4. Mediate through Partnership**

*Mediate and work collaboratively across disciplines, sectors and partners to enhance the impact and sustainability of health promotion actions: Do you agree this domain is core to health promotion practice?*

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>60.0% (33)</td>
<td>4.52</td>
<td>61</td>
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</table>

**Comments**

1. Later, it could become a part of advocacy planning, or awareness raising / based on dialogue, collaboration, partnership.
2. This overlaps too much with other domains.
3. Developing training programmes in a multidisciplinary context (pre and post graduation).
4. And quality of life and environment.
5. I understand and support the 'work collaboratively' portion of this statement, but where does the "mediate" action come from? Is the assumption that health promoters have superior mediation skills that are lacking in other sectors?
6. Too many unclear concepts (disciplines, sectors, partners, enhance, sustainability).
Question 27. Competency 4.1
Identify and engage partners from different sectors who have the potential to actively contribute to the development and implementation of health promotion actions
Do you agree this competency is core to health promotion practice?

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<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
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</tbody>
</table>

Comments
1. Partners ("friends of health promotion") are very important.
2. Enable change 2.1 and Advocacy 3.5.
3. Engage professionals industry, protect the nature, flora and fauna in sense to be people friendly.

Question 28. Competency 4.2
Facilitate intersectoral collaboration by mediating between different sectoral interests
Do you agree this competency domain is core to health promotion practice?

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<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>31.7% (19)</td>
<td>65.0% (39)</td>
<td>4.60</td>
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</tbody>
</table>

Comments
1. Competencies 4.1 and 4.2 are closely linked, and could be merged.
2. Not all health promotion workers are in the position of mediating between sectoral interests.
3. Assessment 7.1?
4. Isn’t this part of 4.1?
5. Important is to build partnership between people, public interests.
6. Why the emphasis on mediation?
7. I don’t understand how this is different to 4.1 It seems to be an integral part of 4.1 and is not necessary?

Question 29. Competency 4.3
Establish and manage effective partnership working with key stakeholders, including statutory bodies, community groups and voluntary/non-governmental organisations
Do you agree this competency is core to health promotion practice?

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<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>50.0% (30)</td>
<td>4.37</td>
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</tbody>
</table>

Comments
1. Work only under democratic principles of partnership and collaboration.
2. Community groups and voluntary org/NGOs yes, statutory bodies no – above the position of many HP workers.
3. See above.
4. Although caveat that this might be a more senior role so it might be about contributing to establishing and managing for more junior roles.
5. What is the difference between this and 4.1 other than a more directed list of partners. Duplicative?
6. Rather ‘facilitate’. Establish and manage is higher level of competencies.
7. And the private/commercial sectors.
### Question 30. Competency 4.4
**Sustain local, regional and national coalitions and networks for health promotion action**
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>4.35</td>
<td>61</td>
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</tbody>
</table>

**Comments**
1. Local and regional coalitions and networks - yes, national and international - no, see remark above.
2. Implementation 9.7.
3. Mostly in a local and regional basis.
4. This would not be an activity possibly.
5. Also neighbourhood unit, invite youngsters, representatives of groups with special needs.
6. Very high level work here - for regional and national.
7. While I strongly agree with this statement - I have reservations about the expectation that an entry level practitioner should be able to work at National level. Working at national level is an advanced practitioner skill that all HP practitioners would have - being aware of and participating in such coalitions and networks would be more appropriate.

### Question 31. Competency 4.5
**Monitor and review partnership working in terms of impact, outcome and adherence to health promotion principles**
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>50.0% (30)</td>
<td>4.37</td>
<td>61</td>
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</table>

**Comments**
1. Evaluation and research 10.2.
3. Agree, but this is an evaluation function, if you are going to be consistent, they you should include a monitoring and review component for every sub set of competencies (e.g. monitor and review the impact of advocacy initiatives).
4. This is contradictory; criteria 4.1-4.4 require partnership but his suggests they have to be ‘reviewed’. What if partners do not adhere to heath promotion principles and one has to stop working with them (e.g. 4.1 etc becomes impossible)?
**Question 32.**
**Do you think there are any other competencies that should be included in the core domain Mediate through Partnership?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tr>
<td>6.8% (6)</td>
<td>93.2% (55)</td>
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</table>

**Comments**

1. To know the right people to make it work. Partnerships by themselves are not enough.
2. Competency 26 is a core competence; 27-31 spells out unnecessary prescriptions and details.
3. Understand that there are different levels of partnership based on expertise and resources.
4. Important to underpin this area with awareness of own impact on others and knowledge of how to build constructive relationships with others - the principles of effective partnership working, the ways in which teams and organisations can work and the different forms that teams and organisations can take.
5. I don’t agree with the emphasis on mediation. Why not just focus on working collaboratively? Mediation is a very specialized skill set that, to the best of my knowledge, is not a primary focus of health promotion training programmes.

**Question 33. Domain 5. Communication**

*Communicate health promotion actions effectively using appropriate methods for diverse audiences:*

**Do you agree this domain is core to health promotion practice?**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</table>

**Comments**

1. At certain points it’s overlapping with mediation through partnership.
2. What are the appropriate methods?

**Question 34. Competency 5.1**

*Use a range of skills including written, verbal, non-verbal and listening skills to communicate effectively with individuals, groups, communities and organisations on health promotion actions*

**Do you agree this competency is core to health promotion practice?**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</table>

**Comments**

1. These are basic skills, and when linking to high leadership skills/competencies, there is no point to put them here.
2. Communication with individuals, groups and communities - core, comm. with organizations – no.
3. A range of skills can not be one competency.
### Question 35. Competency 5.2
Develop written, oral and electronic communication (including reports, presentations and focused messages) that are adapted to specific contexts

**Do you agree this competency is core to health promotion practice?**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>58.3% (35)</td>
<td>4.50</td>
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</table>

**Comments**

1. This could be incorporated in the previous one.
2. If electronic communication includes homepages and web 2.0 applications, no.
3. But see above.
4. This seems to be part of 5.2.
5. Understandable language.
6. Query the rationale of choosing these examples reports, presentations and focused messages. Techniques such as social media and web sites are gaining popularity and will be come more relevant during the life of these competencies. Presentations are not a key tool for a health promoter but I would expect them to be able to write letters - again I suggest the competency is left generalised and doesn’t quote examples.

### Question 36. Competency 5.3
Use the media and current information technologies to receive and disseminate information

**Do you agree this competency is core to health promotion practice?**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>58.3% (35)</td>
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</table>

**Comments**

1. A clear understanding of the media is vital and all staff especially senior staff need to undergo specific media.
2. Competencies 3.4, 3.4, 3.6 and 3.7 could make one ability to communicate efficiently, in terms of available sources, current IT, personal etc.
3. Use the media- way too unspecific; media communication skills are not core.
4. Using and working with the media (thinking here of broadsheets, professional journals etc) is possibly more of a PR role and maybe difficult to access for a layperson.

### Question 37. Competency 5.4
Use effective and culturally appropriate communication methods and techniques for specific groups and contexts

**Do you agree this competency is core to health promotion practice?**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</table>

**Comments**

1. I think it could be joined with 5.1
2. Is this different from 5.1
3. Adapted to culture, habits in migrants.
4. Rather demanding (e.g. language skills)
5. I think it is important but is this not the same as question number 33?
Question 38. Competency 5.5
Use interpersonal communication and groupwork skills to facilitate individuals, groups, communities and organisations to develop personal skills and community action to improve health and reduce health inequities
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>30.0% (18)</td>
<td>63.3% (38)</td>
<td>4.52</td>
<td>61</td>
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</table>

Comments
1. Using skills to facilitate organisations to community action ... not core.
2. Special emphasize for the beginning(children, parents,..).
3. More important is structural development than personal health education.
4. It is obsolete because of the other items.
5. This is criteria for certain kind of personality (outgoing, socially active), not professional criteria.
6. Suggest "reduce" inequalities should be changed to "address" inequalities.

Question 39.
Do you think there are any other competencies that should be included in the core domain Communication?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>11.9% (7)</td>
<td>88.1% (52)</td>
</tr>
</tbody>
</table>

Comments
1. See 5.4 above.
2. I do not see the purpose of fragmenting all these "competencies" in so many parts. Actually I see this structure of questionnaire quite difficult to follow, and have methodological problem of missing (txt missing from pdf).
3. Improve Interpersonal communication strategies.
4. Would structure communication skills differently, spelling out requirements by audience: professional-lay; by target group: individuals-groups-communities-NGOs-GOs; by level: local-regional-national, by channel: written, oral, electronic and their combination whereof. Eg. written communication with various target groups at local level is core, with international organizations is not.
5. Evaluation of communication activities.
6. Demonstrate a knowledge of communication processes.
7. Demonstrate active listening(from 6.1) and accurate reflection.
8. Point 1) Communication should be planned. A communication plan includes well designed objectives, the identification of the target audience, concepts, messages, channels and evaluation system.
   I did not find this idea explicitly stated, in the previous items.
    Point 2) I think that a special obstacle in HP work is the communication of population data.
9. Handicapped and patients needs also health promotion and HE treatment for the rest of quality of life.
10. some questions are overlapping.
**Question 40. Domain 6. Leadership**

Contribute to the development of a shared vision and strategic direction for health promotion actions

Do you agree this domain is core to health promotion practice?

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<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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<td>36.7% (22)</td>
<td>55.0% (33)</td>
<td>4.43</td>
<td>61</td>
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</table>

**Comments**

1. "Leadership" is heavily laden by theories so it should be more explicitly defined than above. Eg. is it individual or social transactional or transformational, in a formal or informal organization? "Contributing to the development of".. is different from "leading the development of..."
2. Because many of the new HP roles do not have a leadership element to them and it would be difficult for this domain to be demonstrated in practical terms.
3. Need to be aware that some HP practitioners will be foot soldiers and not leaders - particularly when it comes to strategic leadership activity.
4. Very broadly worded.

---

**Question 41. Competency 6.1**

Use democratic and empowerment leadership skills including active listening, negotiation, team work, motivation, conflict resolution, decision-making, facilitation and problem-solving skills

Do you agree this competency is core to health promotion practice?

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<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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**Comments**

1. Participatory approaches should be included
2. It is quite unrealistic, I think and unnecessary to look after all these skills all together. And also wonder how all (txt missing from pdf)
3. Motivation and decision-making are among the most important leadership skills, while active listening, negotiation, conflict resolution, etc are not only leadership but management and groupwork skills as well. 6.1 is a confusing statement.
4. There's far too many skills in this, would be impossible to set performance standards
5. contribute, built and create positive climate, respect human rights
6. A lot to expect of all practitioners! Unrealistic to expect all to have this type of leadership - followers are required also !
7. Use them for what?
8. Does this imply that health promotion is only possible for people in leadership position?
9. Agree with the statement but see that conflict resolution is an advanced skill and is a tall order for an entry level practitioner

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**Question 42. Competency 6.2**

Network with and motivate key stakeholders in relevant organisations, including one's own, in leading change to promote health

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
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<tbody>
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<td></td>
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<td>55.0% (33)</td>
<td>4.37</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. WHO is a relevant organisation so networking with it should be core.
2. Overlaps with Partnership and Advocacy domains.
**Question 43. Competency 6.3**
Reflect on learning and achievement needs at individual and organisational levels to build health promotion capacity

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>43.3% (26)</td>
<td>4.17</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments

1. This too often depends on more available resources than on leadership itself.
2. What do you mean by organisational level?
3. Not clearly-enough articulated i.e open to many interpretations.
4. It is rather a higher level of the competence.
5. Would like to see a more active choice of verb than 'reflect'. ‘Address’?
6. I’m not very satisfied with the word reflect.
   Generally the competency is not clear.
7. Reflection is not enough once learning and achievement needs are identified - action has to follow.

**Question 44. Competency 6.4**
Incorporate new knowledge and ideas to improve practice and respond to emerging challenges in health promotion

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>4.50</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments

1. Competency 6.4 is NOT a specifically leadership skill.
2. Perhaps would be universally applicable if related particularly to own area of work.

**Question 45. Competency 6.5**
Mobilise and manage resources for health promotion actions

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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<td>4.43</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments

1. Thematic actions.
2. Managerial level of competency.
Question 46.
Do you think there are any other competencies that should be included in the core domain Leadership?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>11.7% (7)</td>
<td>88.3% (53)</td>
</tr>
</tbody>
</table>

Comments
1. Except that some of them overlap with communication and mediation, and are also part of at least the three other sections: action planning, research and evaluation.
2. Charismatic personality and respectful to other people and ideas.
3. Demonstrate and encourage openness to alternative opinions and strategies. Demonstrate and encourage innovation and creativity in health promotion.
4. Demonstrate knowledge of effective leadership and management processes.
5. These competencies in this category relate to very high system-level visionary leadership. What about more day-to-day operational leadership (managing project teams, etc.)?
6. I think advocacy is more important than leadership. And I don't know if all the competencies mentioned above belong to leadership.
7. One of the gaps in this document is the lack of reference to ethical practice. See comments at end of survey. Ethics do not fit into any one competency they are overriding or underpinning all practice. But if there is not a separate section about ethical practice the Leadership domain should have another competency about ethical practice.

Question 47. Domain 7. Assessment
Conduct assessment of needs and assets in settings and systems that lead to the identification and analysis of the political, economic, social, cultural, environmental, behavioural and biological determinants that promote or compromise health

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
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<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
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<td>8.3% (5)</td>
<td>26.7% (16)</td>
<td>60.0% (36)</td>
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<td>61</td>
</tr>
</tbody>
</table>

Comments
1. Yes, but should not make the assessment domain too segmented and impossible to encompass.
2. This domain (according to the list of competencies listed below) is too scientific. It is suitable for researcher not for “field practitioners”. They do not need to know quantitative and qualitative research methods (a lot of researchers do not know qualitative research methods…). I would simplified all the domain in terms of not “to conduct…” but to participate in cooperation with researchers on conducting assessment of…“.
3. But it could as easily be labelled ‘Planning’.
4. There is again the question of what is appropriate for all levels and HP roles some may contribute to conducting assessments but not be totally responsible - particularly if the assessments form part of a quality assurance audit or inspection.
5. This is core to researchers not to policy makers. Policy makers can use the results of the assessments or finance the assessment but are not asked to be able to conduct it.
6. As a domain statement this is far too long and confused.
7. Too many variables (and social is mentioned twice).
8. I find this sentence to complex. What do you want to say?
9. The list of determinants needs to be consistent throughout the document.
**Question 48. Competency 7.1**  
**Identify priorities for health promotion actions in consultation and partnership with key stakeholders, using available evidence and health promotion principles**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>69.5% (41)</td>
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<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. There are a lot of priorities and it is very difficult to find the best one even in one community (school, town, company).
2. This should not be no.1, but moved to no.8.
3. I agree with the competency but wonder if it fits better in domain 4 ie Partnership.

**Question 49. Competency 7.2**  
**Collect, review and critically appraise relevant data, information and literature**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tbody>
<tr>
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<td>1.7% (1)</td>
<td>10.0% (6)</td>
<td>29.3% (17)</td>
<td>60.0% (36)</td>
<td>4.47</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. So long as this is not just based on a traditional health systems style of what constitutes as 'evidence' should be more on the understanding of the contribution of different 'intelligence' sources.
2. Sometimes this is not possible.... this should be set only as a recommendation .... Often the action need (txt missing from pdf)
3. By collecting data you mean collecting primary or secondary data? Collecting secondary data is core, collecting primary data is not.
4. If so, only in cooperation with researchers.
5. I would add “partially in cooperation with researchers”.
6. According to level and role of individual.
7. Critical distance not criticism.
8. Implies academic orientation.
Question 50. Competency 7.3
Use a variety of assessment techniques including quantitative and qualitative research methods
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
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<td>29.3% (17)</td>
<td>60.0% (36)</td>
<td>4.47</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments
1. I would add - and always strive to develop new techniques that are adapted to the health promotion approach.
2. I agree, but I have got an experience, that some assessment methods are rather 'pro forma'.
3. As written above (in 47.).
4. As written above.
5. Variety is the wrong concept.
   'Appropriate'?  
6. As above.
7. Again this is core to research in the HP field, not to policy making. If by "HP practice" we mean both what the researcher and the policy maker do, then this is not core, because it is not core to both.
8. Not all HP practitioners will use 'research methods' but all will need to use 'analytical or research methods'.
9. The problem is to promote assessment and not health because assessment is often over demanding.
10. Qualitative methods maybe even more important; as they often are disqualified (and too much attention is given to quantitative methods which may be biased and relying on self-feeding statistics), I would put qualitative first.
11. Assessment also covers review and evaluation not just research.

Question 51. Competency 7.4
Engage stakeholders in the assessment process
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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<th>Strongly Agree</th>
<th>Mean</th>
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<td>4.45</td>
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</tbody>
</table>

Comments
1. I think that conducting assessment should be responsibility of researchers. So they should engage stakeholders (including HP practitioners).
2. To engage anybody means to be directly responsible for conducting assessment. And I am really not sure whether this is the role of HP practitioners (I think it is not). I would rather reformulate this competency "Cooperate with researchers and other stakeholders in the assessment process".
3. Use participative approaches to...
Question 52. Competency 7.5
Use culturally appropriate assessment approaches
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>56.7% (34)</td>
<td>4.38</td>
<td>61</td>
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</tbody>
</table>

Comments
1. “Culturally appropriate” is a term to be infinitely stretched.
2. First of all it is necessary to identify culturally appropriate approach and again I think it is the task more for HP researchers than practitioners.
3. First of all it is necessary to identify culturally appropriate assessment approach and again I think it is the task for HP researchers.
4. Culturally’ is only one form of appropriateness.
5. Assessment methods may have that flexibility but interpretation and presentation certainly should have.
6. Also create a new culture.
7. Too demanding.
8. This is essential and will often be governed by ethical considerations.

Question 53. Competency 7.6
Identify existing assets and resources in individuals, organisations and communities
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>43.3% (26)</td>
<td>51.7% (31)</td>
<td>4.47</td>
<td></td>
</tr>
</tbody>
</table>

Comments
1. Link to comment in 7.2 above.
2. Identifying existing assets and resources in individuals and communities is core, in organisations is not - most practitioners are not in that position.

Question 54. Competency 7.7
Identify political, economic, social, cultural, environmental, behavioural and biological determinants which impact on health
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>43.3% (26)</td>
<td>51.7% (31)</td>
<td>4.47</td>
<td></td>
</tr>
</tbody>
</table>

Comments
1. But this should come before 7.6.
2. PRECEDE - PROCEED model.
3. Too demanding.
4. This is only relevant if related to a specific context or health promotion action - once these factors are identified then what?
**Question 55. Competency 7.8**
Identify the key drivers for and barriers to health promotion action
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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<th>Mean</th>
<th>Respondents</th>
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</table>

No Comments

**Question 56.**
Do you think there are any other competencies that should be included in the core domain Assessment?

<table>
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<tbody>
<tr>
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</tr>
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</table>

Comments
1. Demonstrate understanding of how to overcome barriers and potentiate action. Establish KISS principles.
2. I have just a comment: people without basic skills of epidemiology, are unlikely to accomplish these tasks.

**Question 57. Domain 8. Planning**
Develop measurable health promotion goals and objectives in response to assessment of needs and assets and identify strategies that are based on knowledge derived from theory, evidence, practice and consultation with stakeholders

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>4.63</td>
<td>61</td>
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</tbody>
</table>

Comments
1. I agree, but not at all costs.
2. Reads like 7.1.
3. Again would suggest there is a need to consider contribute to the development of as the role and level of the individual will determine whether they have the authority to plan particularly in a strategic context.
4. Again domain description is far too long and complex.
5. Criteria 1 implies that theory, practice etc. of health promotion are defined and belong to core competence of health promotion professional. This criteria implies that measurable goals and objectives etc. do not actually exist. Which one is correct?
### Question 58. Competency 8.1
Use a systematic approach to health promotion action planning

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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</thead>
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<td>0.0% (0)</td>
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<td>61.7% (37)</td>
<td>4.62</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. A systematic and integrated.
2. This is not a competency but part of it - an attitude.
3. See reservations re level and role applies to all the following as well.
4. Not only, we should be open with new ideas.
5. But maybe it needs a more clear wording.
6. Maybe not specific enough.
7. I agree with this comment but wonder just what systematic means - there are many systems and are all equally acceptable for the purposes of assessing competence? Some trends are towards ‘logic intervention/outcome’ systems/models.

### Question 59. Competency 8.2
Develop and communicate appropriate, realistic and measurable goals and objectives

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</tr>
</thead>
<tbody>
<tr>
<td>0.0% (0)</td>
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<td>38.3% (23)</td>
<td>61.7% (37)</td>
<td>4.62</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. HP is a complex and long term process often hard to measure
2. Appropriate and realistic!
3. Goals should be set WITH people
4. often the unintended goals are much more important than the intended
5. This competency implies that the health promoter could develop the goals etc - this competency could be strengthened by a requirement to developing in partnership

### Question 60. Competency 8.3
Identify an appropriate mix of strategies to achieve objectives

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tr>
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<td>66.7% (40)</td>
<td>4.58</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. If adequate.
2. This is not a competency.
3. Objectives are achieved by doing, not by identifying strategies.
4. Understanding that objectives will be achieved by a mix of strategies not just a single strategy is integral to good hp practice.
### Question 61. Competency 8.4

**Identify and secure resources (skills, personnel, partner contributions, finance, materials, training and support) for sustainable health promotion**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
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<td>1.7% (1)</td>
<td>5.0% (3)</td>
<td>26.7% (16)</td>
<td>66.7% (40)</td>
<td>4.58</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. This is not a competency.
2. Identify and secure : 2 different ideas.
3. This is going to be difficult regardless of role and level within an organisation it might be more appropriate to be able to work with budgets and allocated resources and to be able to develop business cases for sustainable health promotion initiatives.
4. May not always be within the remit of the HP practitioner to actually secure appropriate resources.

### Question 62. Competency 8.5

**Identify and secure resources (skills, personnel, partner contributions, finance, materials, training and support) for sustainable health promotion**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>1.7% (1)</td>
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<td>66.7% (40)</td>
<td>4.58</td>
<td>61</td>
</tr>
</tbody>
</table>

**Comments**

1. This is a competency that requires 8.1-8.4 (among others).
2. Again level and role with constrain against this being an appropriate competency for all practitioners.
3. if you have an action plan, you have identified the resources, and an appropriate mix of strategies and you have defined some goals. So you use a systematic approach to health promotion action planning. = project management.

### Question 63. Competency 8.6

**Mobilise support and engage the participation of key stakeholders**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<tbody>
<tr>
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<td>4.57</td>
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</tr>
</tbody>
</table>

**Comments**

1. Stakeholders at various levels (local, regional, national, international) should be distinguished - engaging national or international stakeholders is not a core competency.
2. And LC, people.
Question 64.
Do you think there are any other competencies that should be included in the core domain Assessment?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.3% (9)</td>
<td>84.7% (50)</td>
</tr>
</tbody>
</table>

Comments
1. Skills in fundraising.
2. Participation and dialogue with all the involved people creating a common vision.
3. Good planning is the basis to assess the effectiveness of health promotion actions. (Also the economics should be taken account)
4. Demonstrate an understanding of planning models.
5. Design an appropriate monitoring system.
6. Plan for evaluation of health promotion actions.
7. Involve people.
8. It may be useful to re-word the competencies in a way that distinguishes between broader ‘strategic’ planning and more operational (program-oriented) planning activities.
10. Reluctant to suggest more competencies but provision for evaluation is essential in programme planning. Could this be added into one of the existing competencies perhaps 8.1 or 8.5.

Question 65. Domain 9. Implementation
Implement effective and efficient, culturally sensitive and ethical health promotion strategies to ensure the greatest possible improvements in health, including management of human and material resources

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<th>Mean</th>
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<td>69.0% (41)</td>
<td>4.63</td>
<td>61</td>
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</tbody>
</table>

Comments
1. Would recommend to use the EU definition as to what "strategy", "programme", and "project" mean, see here: http://ec.europa.eu/europeaid/evaluation/methodology/methods/mth_pps_en.htm
Implementing a project is core competency, implementing a programme or strategy is not.
2. This is the first appearance of ‘ethics' and ethical issues should be in every domain.
3. The item has a rather all-inclusive character, it seems difficult to identify specific competencies.
4. Too demanding.
**Question 66. Competency 9.1**  
**Use culturally relevant and appropriate health promotion implementation approaches**  
*Do you agree this competency is core to health promotion practice?*

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</tbody>
</table>

**Comments**

1. Again, cultural is only one form of appropriateness.
2. If the culture is supportive, not only health goal, but also people.
3. Are there really standard approaches?
4. Agree, if "culturally relevant" does not include stigma, intolerance, tradition of social exclusion, institutionalisation of persons from vulnerable groups, etc.

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**Question 67. Competency 9.2**  
**Use culturally relevant and appropriate health promotion implementation approaches**  
*Do you agree this competency is core to health promotion practice?*

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Strongly Agree</th>
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</tbody>
</table>

**Comments**

1. But do not forget to include an element of pragmatic realism in the learning.
2. Empowering processes are the most important, which could include social, and cultural capital, resilience, sense of coherence and so on.
3. "Ethical" should be defined.
4. Strongly agree with this comment but it is not sufficient reference to ethics. Values and ethics underpin all aspects of health promotion practice and action. The ethics health promotion action should not change according to specific contexts. The same ethical principles underlie all contexts. Suggest that the competencies contain a strong message in the introductory sections about the values and ethics underlying health promotion practice.

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**Question 68. Competency 9.3**  
**Develop, pilot and use appropriate programme resources and materials**  
*Do you agree this competency is core to health promotion practice?*

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<td>61</td>
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</tbody>
</table>

**Comments**

1. Level of practitioner will potentially mitigate against this being part of their job role and therefore they would contribute to this activity.
2. Unclear.
### Question 69. Competency 9.4
Monitor the quality of implementation of programmes in relation to agreed goals and objectives

Do you agree this competency is core to health promotion practice?

<table>
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<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
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<td>4.54</td>
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</tbody>
</table>

Comments

1. As above.
2. This has been done quite much already.
3. This belongs in the evaluation set of competencies.

### Question 70. Competency 9.5
Use process evaluation feedback to maintain and improve effective implementation

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
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<th>Uncertain</th>
<th>Agree</th>
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<td>4.53</td>
<td>61</td>
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</tbody>
</table>

Comments

1. PRECEDE - PROCEED model-
2. As above.
3. As above.
4. Applies only to certain types of activity.
5. Process evaluation is a term used for a particular style of evaluation - is this what was intended? Suggest that 'process evaluation' is too limited The statement should be left more general to allow for other styles of evaluation. Suggest removing the word 'process'.

### Question 71. Competency 9.6
Manage the resources needed for effective implementation

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
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<th>Mean</th>
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<td>4.36</td>
<td>61</td>
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</table>

Comments

1. As above many practitioners are not in control of resources.
2. Would apply if relevant to own work - but not necessarily applicable to the overall programme implementation.
3. May be this is covered be the previous competencies in this section.
Question 72. Competency 9.7
Facilitate programme sustainability and stakeholder ownership through ongoing consultation and collaboration

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
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<td>55.9% (33)</td>
<td>4.51</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments
1. All above can be considered part of the core competency for project implementation, but not for programme or strategy implementation. As above many practitioners are not in control of resources.
2. Sustainability is achieved by building appropriate systems.

Question 73.
Do you think there are any other competencies that should be included in the core domain Implementation?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>6.8% (4)</td>
<td>93.27% (54)</td>
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</tbody>
</table>

Comments
1. See comment in 9.2 above

Question 74. Domain 10. Evaluation and Research
Determine the reach, effectiveness and impact of health promotion actions. This includes utilising appropriate evaluation and research methods to support programme improvements, sustainability and dissemination

Do you agree this domain is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>66.1% (39)</td>
<td>4.51</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments
1. Determining the impact (if it means long-term outcome) or the effectiveness of health promotion actions is not a core competency; determining the reach and short-term outcome is.
2. I think it would be better to have external educated evaluator.
3. This domain is more suitable for researchers than practitioners.
4. This domain is Evaluation. Research needs its own domain. 10.4 is not adequate for research.
5. Role and level of practitioner may mitigate against this being a reality - although it is understood that the competencies are meant for graduates and post graduates many roles are now located around level 3 or level 4.
6. Can wording be synthesized to eliminate two sentences.
7. Too demanding (there is no set criteria for sustainability, for example).
### Question 75. Competency 10.1
**Integrate evaluation into the planning and implementation of all health promotion actions**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
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<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
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</table>

**Comments**

1. Predicated on reasonable reality i.e. if a one off short piece of work the evaluation needs to reflect that.
2. Sometimes we evaluate and evaluate in clear situation (everybody knows result before) - it takes time and money.
3. With caveat that it may not be relevant to practitioners below level 5.
4. Most not possible.
5. Contradictory with other criteria.

### Question 76. Competency 10.2
**Use appropriate health promotion evaluation and monitoring methods and tools in partnership with stakeholders to record process, impact and outcome evaluation**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
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<td>61.3% (36)</td>
<td>4.49</td>
<td>61</td>
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</tbody>
</table>

**Comments**

1. Health promotion staff need to be reminded that a major influence on this whole section is the funder and what are their reporting requirements, if we are not the funder and are looking for different information this may cause conflict and affect capacity.
2. Competencies 10.1, 10.2 and 10.3 I see them inseparable, on the other hand they often do not all need to be implemented.
3. See my comment above about impact evaluation.
4. As above.
5. I am just not sure - probably "appropriate health promotion evaluation" causes it. And the competencies is not here best of possibilities in that section.
6. Also people who are involved with process should be part of evaluation.
7. Suggest replacing "record" with "conduct".

### Question 77. Competency 10.3
**Use evaluation findings to refine and improve health promotion actions**

Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
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<td>32.2% (19)</td>
<td>66.1% (39)</td>
<td>4.64</td>
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</tbody>
</table>

**Comments**

1. Use findings to refine and improve health promotions they carry out but not for a general improvement.
2. As above.
Question 78. Competency 10.4
Use research and evidence based strategies to inform practice
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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<th>Strongly Agree</th>
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<td>56.9% (33)</td>
<td>4.48</td>
<td>61</td>
</tr>
</tbody>
</table>

Comments
1. Please keep the emphasis on 'inform' rather than 'based'.
2. It is the competency for HP leaders/managers, not for "daily HP practitioners". They should be "just" informed.
3. But this competency is only one part of doing and using research.
4. This is part of 10.3.
5. Depends on which level and of understanding.

Question 79. Competency 10.5
Contribute to the planning, conducting and writing of evaluation initiatives
Do you agree this competency is core to health promotion practice?

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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<td>4.31</td>
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</tbody>
</table>

Comments
1. 'Contributing to' is a weakening of the competence - who does it?
2. Suggest this is going to only relevant to a small number of senior level practitioners.
3. May this is redundant.
4. Suggested rewording: "Contribute to the planning, implementation and documentation of evaluation initiatives."
5. Not clear.

Question 80.
Do you think there are any other competencies that should be included in the core domain Implementation?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.8% (4)</td>
<td>93.27% (55)</td>
</tr>
</tbody>
</table>

Comments
1. Please see comments in 10.1 and 10.2 above.
2. The title of this chapter is Evaluation and research but the content is only evaluation without Research.
3. There are similar question in this domain and in the previous "implementation".
4. If this domain is evaluation & research, then more competencies are needed for research.
5. What means really evaluation?
### Question 81.

**Are there any domains that you would like to see added to the framework document?**

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<table>
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<tbody>
<tr>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td>13.6% (8)</td>
<td>86.4% (51)</td>
</tr>
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</table>

### Comments

1. I think the domains outlined provide key skills and competencies a HP worker should have.
2. Some are overlapping, some are too segmented, while all should be seen integrated in the various levels of the framework.
4. I feel there needs to be some reference the substantive area of expertise, e.g. nutrition, substance use and abuse, mental health etc.
5. What about health promotion theory?
6. Capacity-building; Community Development (see my response of previous round)
7. We don’t know how fast global world will be developed in technology and scientific way therefore we need a scenario for 2050.
8. In terms of regulation it is important to emphasise professional and ethical practice. Arguably this should be part of any professional competency framework for HP and should be separately identified in its own domain.
9. Evaluation of health promoters ideals and work, are they harmful in some case?
   - Involvement and empowerment are very important.
   - Should health promoters create culture, not follow it? An if so, it is very important that we do not create more inequalities with this work.
10. The use of practical knowledge is underestimated because in complex intervention you have not a evidence base you need models of good practices.
11. I don’t want to see the number of Domains increased but do want to see stronger mention of values and ethics mentioned in the introductory sections. Ethics are essential to good practice and can not be isolated to any one context or Domain. There needs to be some ethical guidelines or reference to what is meant by ethical health promotion actions.
Question 82.
Are there any domains that you would like to see removed from the framework document?

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td></td>
<td>13.6% (8)</td>
<td>86.4% (51)</td>
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</tbody>
</table>

Comments
1. Is it possible to integrate for instance; Assessment, Evaluation?
2. Assessment Domain and Evaluation and Research Domain should be removed or reformulate as they are more theoretically oriented and should be the domains for researchers (in such context as seen in document).
4. Mediate through partnership.
5. As I wrote for the 1st round, I don’t feel fully comfortable with the knowledge domain. I understand the choice made to highlight core knowledge in HP but I think each domain of core competencies requires a set of knowledge. A shared knowledge framework based on the final competencies framework may be a 2nd step.
6. The last 2 domains included very similar questions.
7. Regarding the different level of development in the EU countries and the future coming countries is important to have in mind the possibility of time achieving change but, we can manage together.
8. Some of these are basic stuff, but some of them are more deeper, maybe it could be for ex. 5 stages, which are different with demands.
9. Evaluation is a scientific construct; in complex interventions outcome measurements often preferred compared to evaluation approaches.
10. The leadership set of competencies did not resonate with me. They were very broadly defined and somewhat ambiguous. There was also a tacit assumption that health promotion practitioners had the necessary stature and seniority within their respective organizations to be able to assume this level of leadership. I suggest reviewing these competencies with an eye towards re-wording and possibly eliminating them altogether.
11. All competencies are necessary but I hope someone else might have some ideas how to consolidate some to reduce the number.

Question 83.
Overall, I would rate the framework as:

<table>
<thead>
<tr>
<th></th>
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<th>Poor</th>
<th>Uncertain</th>
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<th>Very Good</th>
<th>Mean</th>
<th>Respondents</th>
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<td>58.6% (34)</td>
<td>4.47</td>
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</tbody>
</table>

Comments
1. So many very good ideas and claims. Who would not agree with all of them? But sometimes less is more.
2. Give more importance to participation of people.
3. Very useful in teaching goals.
4. Very ambitious.
5. It is still rather lengthy for a framework that will be widely used so anything that can be done to reduce unnecessary length and add clarity would be welcome.
6. It has all important aspects in, but sometimes it is difficult to say what is really important. In HP these all are important, but in daily work, you need different skills and aspects and sciences.(Social, ed, psych, etc science are needed).
7. Congratulations to the working group, overall the competencies are great and a huge improvement on the first round.
### Question 84

**The framework adequately reflects current health promotion practice**

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
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<th>Strongly Agree</th>
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</table>

**Comments**

1. Am only uncertain because I do not know for certain that there is equity across all other countries in accepting and understanding what we all accept as current practice.
2. This is more a goal than a picture of practice.
3. The framework is not dynamic, not developmental, or culturally sensitive.
4. The framework reflects wishful thinking (the idealistic practice of the Ottawa Charter).
5. At least in France from my perspective this framework is much more ambitious than current HP practice. However, I think that it gives a framework to work towards.
6. What about health promotion theory?
7. It is still too idealistic, too scientific. This framework is more "how it should be" than how it really is in practice.
8. There is an issue with roles and levels of practitioners in that the framework will potentially be exclusive and be more relevant to senior HP specialists who have the opportunities to demonstrate their knowledge and understanding across all domains but it will miss out on those who are at levels 2 to 4.
9. The framework should improve the current HP practice.
10. Practice is far behind of the proposed framework, but it is very important to improve practice.
11. However they should.
12. I hope but there should be a critical reflection in the scientific community about this.
13. In the region I know (Eastern part of Europe) most of these principles are not being implemented in practices, as the health systems are fully controlled by lobby of specialized medicine.
14. Ambitions are very high with these competencies. One might be very able within some domains, and less able within other domains. Nevertheless: these standards are very desirable for future public health!
15. Aspects of current practice not reflected in the competencies are: - human rights base approaches to health promotion - code of ethics - health literacy and – sustainability.
**Question 85**
The framework will be useful in developing workforce capacity for health promotion in Europe

<table>
<thead>
<tr>
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<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
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</table>

**Comments**
1. Providing we are clear as to what value employers will place on this tool without their active support this will potentially not achieve its full potential, we know this from UK experience.
2. Somewhere by some initially but later by more.
3. Not applicable in all countries, not enough cultural or context sensitive.
4. I hope, but I am not sure.
5. It is not yet so clear how it will be applied.
7. Because of the limitations and the potential exclusion of some practitioners then it might exclude areas such as health champions and health trainers who are growing in numbers and are part of the HP workforce in my country.
8. With emphasis on my comment earlier about length. Will also be necessary to map across to what frameworks are already being used in the different countries to avoid duplication.
9. And I hope in it very much.
10. What are those real core competencies in health promotion? All these include HP, but how we make HP live? How make tacit knowledge visible?
11. The framework should be reflected on the existing hp curricula in Europe.
12. Would say 'strongly agree’ but I don't know enough about the European context.

**Question 86**
The framework will assist in planning health promotion workforce capacity for the future

<table>
<thead>
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</table>

**Comments**
1. Link to comment in 85.
2. I hope but I am not sure.
3. In theory I strongly agree but in practice I still have some doubts.
4. The framework is prescriptive and way too wide at the same time.
5. Is this different from 85?
6. There needs to be a skill mapping exercise first which depends on political will.
7. Frankly, I see it as "the framework would”.
8. See remark 85.
### Question 87
The framework adequately reflects the evidence base for good practice in health promotion

<table>
<thead>
<tr>
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<td>5.1% (3)</td>
<td>10.2% (6)</td>
<td>39.0% (23)</td>
<td>45.8% (27)</td>
<td>4.25</td>
<td>59</td>
</tr>
</tbody>
</table>

**Comments**

1. Evidence base does not really cover all areas yet-
2. Not all evidence, of good practice in HP is available, unfortunately.
3. This would require a lot more detail.
4. The competencies do reflect an evidence base but ignore the evidence around human rights

### Question 88
The framework adequately reflects the ethical dimensions of health promotion and their application in practice

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Uncertain</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Mean</th>
<th>Respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.0% (0)</td>
<td>6.8% (4)</td>
<td>11.9% (7)</td>
<td>44.1% (26)</td>
<td>37.3% (22)</td>
<td>4.12</td>
<td>59</td>
</tr>
</tbody>
</table>

**Comments**

1. Ethics remains rather practical, more fundamental understanding of would benefit more (e.g. which values drive - txt missing from pdf).
2. Ethical issues rarely mentioned.
3. Human rights dimension respecting everybody.
4. See earlier comment about separate domain.
5. I think the ethical dimension is sadly lacking – please refer to my comments earlier in the questionnaire.
**Question 89.**
*If you have any suggestions on how to improve the framework as a whole or specific competencies please give detailed feedback here.*

<table>
<thead>
<tr>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. See above</td>
</tr>
<tr>
<td>2. I would completely restructure the framework and not merely reiterate the US competency framework. See my earlier comments.</td>
</tr>
<tr>
<td>3. An agreed model of HP planning and delivery (e.g.PRECEDE-PROCEED) would allow anyone to see how you think the jigsaw pieces fit together</td>
</tr>
<tr>
<td>4. I have three considerations: 1. it is essential to emphasize the importance of strong epidemiological skills (perhaps by expanding the knowledge. 2. importance of some skills in training adult people and 3. A final issue is more subtle: we should distinguish clearly the assessment of health impacts from scientific research. Practice and research are interconnected, of course; but the practical evaluation should be tied to context and the attitude of the practitioner should be different from that of the researcher: The practical assessment is used to improve service, not for academic purposes.</td>
</tr>
<tr>
<td>5. Even though in the guidelines you made it clear what you meant by core competences (you refer to all HP practitioners), I found it hard to define what is core. For example, assessment indeed is core, but to be able to conduct an assessment I don't think it is core. I think that it could help to define different HP roles, because this could help to identify competences, and consequently to develop standards and an accreditation system. Thanks for your work!!</td>
</tr>
<tr>
<td>6. Thanks for the questionnaire. A lot of success in it. All the best.</td>
</tr>
<tr>
<td>7. What is the rationale for the order of the domains?</td>
</tr>
<tr>
<td>8. In my country the emphasis is on a unified public health workforce so we will need to see this as contributing to that competence development. There is nothing within the overall public health competence framework (at PH practitioner level) that health promotion practitioners should not be able to achieve. Local Assessment pilots to test this out are now under way.</td>
</tr>
<tr>
<td>9. Because of the importance of such a framework a process of discussion should be promoted</td>
</tr>
<tr>
<td>10. Suggestions provided in comments boxes throughout.</td>
</tr>
<tr>
<td>11. This document could be improved by the inclusion of the list in question 84 plus acknowledgement of the spiritual dimension of health and the indigenous peoples of Europe. The format of the document makes it easy to read and seems satisfactory. Congratulations to the working group, overall the competencies are great and a huge improvement on the first round.</td>
</tr>
</tbody>
</table>

**Question 90.**
*Please indicate which professional area you work in?*

<table>
<thead>
<tr>
<th>Practice</th>
<th>Policy</th>
<th>Academia</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.5% (18)</td>
<td>27.1% (16)</td>
<td>42.4% (25)</td>
</tr>
</tbody>
</table>

**Question 91.**
*Please indicate your level of professional education*

<table>
<thead>
<tr>
<th>Bachelors Degree</th>
<th>Postgraduate Diploma</th>
<th>Masters Degree</th>
<th>Doctorate</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4% (2)</td>
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<td>30.5% (18)</td>
<td>54.2% (32)</td>
<td>5.1% (3)</td>
</tr>
</tbody>
</table>

**Question 92.**
*Does the term ‘Health Promotion’ appear in your educational qualification?*

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.5% (18)</td>
<td>69.5% (41)</td>
</tr>
</tbody>
</table>
Question 93. How many years have you been working in the field of health promotion?

<table>
<thead>
<tr>
<th></th>
<th>1-5 Years</th>
<th>5-10 Years</th>
<th>10-15 Years</th>
<th>15+ Years</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.3%</td>
<td>15.3%</td>
<td>18.6%</td>
<td>42.4%</td>
<td>8.5%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question 94. Have you any previous experience of working with health promotion or public health competencies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>83.1% (49)</td>
</tr>
</tbody>
</table>

Question 95. What country are you representing?

<table>
<thead>
<tr>
<th>Country</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portugal</td>
<td>3</td>
</tr>
<tr>
<td>Finland</td>
<td>3</td>
</tr>
<tr>
<td>Macedonia</td>
<td>3</td>
</tr>
<tr>
<td>Italy</td>
<td>4</td>
</tr>
<tr>
<td>Slovakia</td>
<td>1</td>
</tr>
<tr>
<td>France</td>
<td>2</td>
</tr>
<tr>
<td>Hungary</td>
<td>3</td>
</tr>
<tr>
<td>Estonia</td>
<td>1</td>
</tr>
<tr>
<td>Germany</td>
<td>2</td>
</tr>
<tr>
<td>Lithuania</td>
<td>2</td>
</tr>
<tr>
<td>UK</td>
<td>3</td>
</tr>
<tr>
<td>Ireland</td>
<td>3</td>
</tr>
<tr>
<td>Greece</td>
<td>1</td>
</tr>
<tr>
<td>Croatia</td>
<td>3</td>
</tr>
<tr>
<td>Iceland</td>
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<td>Spain</td>
<td>4</td>
</tr>
<tr>
<td>Denmark</td>
<td>1</td>
</tr>
<tr>
<td>Sweden</td>
<td>3</td>
</tr>
<tr>
<td>Netherlands</td>
<td>2</td>
</tr>
<tr>
<td>Czech Rep</td>
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</tr>
<tr>
<td>Latvia</td>
<td>1</td>
</tr>
<tr>
<td>Norway</td>
<td>1</td>
</tr>
<tr>
<td>Malta</td>
<td>2</td>
</tr>
<tr>
<td>Slovenia</td>
<td>2</td>
</tr>
<tr>
<td>Luxembourg</td>
<td>1</td>
</tr>
<tr>
<td>Poland</td>
<td>1</td>
</tr>
<tr>
<td>Cyprus</td>
<td>4</td>
</tr>
<tr>
<td>Not specified</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5
Focus Group Questions

1. Is the scope and content of the CompHP Core Competencies Framework Draft X appropriate for core Health Promotion practice in Europe and/or in your country?
   1.1 The CompHP Core Competencies Framework Draft 4 is designed for use by health promotion practitioners whose main role and function is health promotion and who have a graduate or post graduate qualification in health promotion or a related discipline.
   1.2 Are there practitioners that fit this description in your country/context?
   1.3 Is this definition too restrictive for your country context?

2. How do you see the competencies being used? (e.g. as a standalone framework or as part of quality assurance/accreditation)
   2.1 What do you see as the main levers or drivers for implementing the competencies?
   2.2 What do you see as the main barriers to implementing the competencies?

3. Do you think the competencies will be used in the context of capacity building and forward planning and future scoping for health promotion for the next 20 years?

4. How do you see the CompHP Core Competencies Framework relating to the development of competencies in other areas such as public health?

5. Any other comments?
Focus Group Consent Form

Consent to Participate in Focus Group Study as part of the CompHP Project ‘Developing Core Competencies in Health Promotion’

PLEASE SIGN THIS FORM AND BRING IT WITH YOU TO THE FOCUS GROUP

I consent to take part in focus groups exploring my ideas on the CompHP Core Competencies for Health Promotion Framework Draft 4

I also consent to having this session and my comments recorded.

The purpose of the group discussion and the nature of the questions have been explained to me.

I understand that none of my opinions will be shared outside of the research group unless all identifying information is removed first.

The information that I provide during the focus groups will be grouped with answers from other people so that I cannot be identified.

The original audio-tape recordings will be stored securely for transcription, after which they will be destroyed.

My participation is voluntary, I understand that I am free to leave the group at any time.

________________________________  _____________________
Please Print Your Name     Date

________________________________
Please Sign Your Name
Appendix 6: Handbook
The CompHP Core Competencies Framework for Health Promotion Handbook

Compiled by

Ms. Colette Dempsey
Ms. Barbara Battel-Kirk
Professor Margaret M. Barry

Health Promotion Research Centre
National University of Ireland Galway

February 2011
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  How were the CompHP Core Competencies developed? ............................................. 2
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Acknowledgements

The authors would like to thank all the CompHP partners who reviewed and commented on each stage of the development of this Handbook. We would also like to thank the International Advisory Group who provided very valuable insights, guidance and support to the development process of these competencies.

A special thanks is extended to all the health promotion professionals across Europe who have given so generously of their time and expertise in contributing to the Delphi process, the focus groups and online consultations.

Finally we would like to thank the Executive Agency for Health and Consumers who provided the funding for the CompHP Project.
INTRODUCTION

The core competencies presented in this Handbook were developed as part of a European project entitled ‘Developing Competencies and Professional Standards for Health Promotion Capacity Building in Europe’ (CompHP), which is funded by the European Agency for Health and Consumers.

This is the first in a series of three Handbooks to be produced by the CompHP project and will be followed by Handbooks on Professional Standards and a Pan-European Accreditation Framework for Health Promotion. The CompHP Project will also publish reports on the processes undertaken in developing the core competencies, professional standards and accreditation framework and their testing in academic and practice settings. The CompHP Handbooks and reports will be widely disseminated throughout the EU member states and candidate countries and will be available on the CompHP website.

The CompHP Project

The aim of the CompHP project is to develop competency-based standards and an accreditation system for health promotion practice, education and training that will have a positive impact on workforce capacity to deliver public health improvement in Europe. The CompHP Project brings together 24 European partners from the professional development, policy, practice and academic sectors in health promotion. The work of CompHP is also supported by an International Advisory Group of experts with experience of the development of health promotion competencies at a global level (see Appendix 1 for a full list of CompHP partners and members of the International Advisory Group).

The CompHP Project employs a consensus building process based on consultation with key stakeholders in health promotion across Europe and builds on existing European and global competency frameworks for health promotion. In particular, it is informed by work undertaken by the European Regional Sub Committee on Training, Accreditation and Professional Standards of the International Union for Health Promotion and Education (IUHPE), which developed and supported the groundwork for the CompHP Project, including undertaking a feasibility study.

Context and Rationale for Developing Core Competencies for Health Promotion

A competent workforce that has the necessary knowledge, skills and abilities in translating policy, theory and research into effective action is recognised as being critical to the future growth and development of global health promotion (2, 3, 4, 5). Identifying and agreeing the core competencies for effective health promotion practice, education and training is acknowledged as being an essential component of developing and strengthening workforce capacity to improve global health in the 21st century (6, 7, 8).

1 http://www.iuhpe.org/?page=614&lang=en
Within the pan-European context, health promotion goals are clearly identified in EU strategies but, there has been no agreement to date on Europe-wide competencies, standards or accreditation systems to assure quality standards in reaching those goals. The development of the CompHP Project was driven by recognition of the need for a coherent competency based framework that would build on related national and international developments. Other key drivers for the project included: freedom of employment policies highlighting the need for agreed standards to facilitate employment across the EU; quality assurance issues for practice, education and training identified within all health fields in Europe; and clarity on workforce capacity required for promoting health and addressing inequalities as identified in EU strategies.

It was also recognised that health promotion is an evolving field in Europe with a diverse and growing workforce drawn from a range of disciplines, and operating in a variety of settings and across a wide range of political, economic and social contexts. Given this diversity, there is a need for core competencies which delineate the specific body of skills, knowledge and expertise that represents, and is distinctive to, health promotion practice (7, 8) to unify and strengthen health promotion workforce capacity across Europe.

What are Core Competencies?

The definition of competencies used in this Handbook is: ‘a combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion,’ (adapted from Shilton et al. 2001) (9). Core competencies are defined as the minimum set of competencies that constitute a common baseline for all health promotion roles i.e. ; ‘they are what all health promotion practitioners are expected to be capable of doing to work efficiently, effectively and appropriately in the field’ (10).

How were the CompHP Core Competencies developed?

The key elements in the development process for the CompHP Core Competency Framework for Health Promotion were:

- A review of the international and European literature on health promotion competencies (11)
- An initial draft framework of core competencies based on findings from the literature review and consultation with project partners
- A Delphi survey on the draft core competencies undertaken with health promotion experts from across Europe to reach consensus
- Focus groups with health promotion experts and other key stakeholders from across Europe

---

2 The sample for the two rounds of the Delphi Survey comprised six representatives from a total of 34 European countries, two from each of the areas of practice, policy, and academia selected on, in order of priority: national role in health promotion, experience in health promotion, and experience in the competency approach.
• Consultation with health promotion stakeholders across Europe using a web based consultation process.

The CompHP project partners and the International Expert Advisory Group advised on each stage of the development process. The CompHP core competencies are, therefore, the result of a wide-ranging consultation process and draw on the international and European literature, in particular:

• The domains of core competencies outlined in the Galway Consensus Statement (7), together with the modifications to the statement suggested in a global consultation process
• The core competencies for health promotion developed in Australia (10), Canada (12), New Zealand (13) and the UK (14)
• Core competencies developed in related fields such as public health (15, 16) and health education (17).

Who are the CompHP Core Competencies for?

The CompHP core competencies are primarily designed for use by health promotion practitioners whose main role and function is health promotion and who hold a graduate or post graduate qualification in health promotion or a related discipline3,4.

A health promotion practitioner is defined as a person who works to promote health and reduce health inequities using the actions described by the Ottawa Charter (18):

• building healthy public policy
• creating supportive environments
• strengthening community action
• developing personal skills
• reorienting health services.

While job titles and academic course titles in different countries across Europe may not always include the term ‘health promotion’, the core competencies are designed to be relevant to all practitioners whose main role reflects the definition and principles of health promotion defined in the Ottawa Charter (18). Health promotion practitioners require specific education and training together with ongoing professional development to maintain the particular combination of knowledge and skills required to ensure quality health promotion practice.

3 Including, for example, public health, health education, social sciences including psychology, epidemiology, sociology, education, communication, environmental health, community, urban or rural development, political science. This is not an exclusive list as other academic qualifications may also be deemed as appropriate in given situations.

4 While a formal qualification in health promotion or related discipline is the general required minimum standard for entry into the profession, it is recognised that there are practitioners who entered the field without a formal qualification. For this group, these competencies provide a framework for assessing and helping achieve formal recognition for relevant past experience.
While the competencies articulated in this Handbook are aimed at entry level practitioners, acquiring a competency is not a one-time event, but rather an ongoing process. Formal training is one means of acquiring entry level competencies, however, ongoing learning through experience, coaching, feedback and individual learning activities are required to develop advanced competencies and maintain the knowledge and skills required by changing practice and policy (19).

Much discussion has centred on the appropriate level for these core competencies and it has been agreed that they are at ‘entry level’ i.e. the level at which a practitioner enters practice. This does not imply that all health promotion practitioners are limited to that level. The core competencies can, for example, provide the basis for developing more advanced competencies for practitioners working at senior management level in health promotion or inform the development of specialised competencies for those who work in specific settings.

It is also recognised that those using the CompHP Core Competencies may wish to identify different levels of expertise for some or all of the competencies or to emphasise some competencies to a greater degree than others. However, as these are core competencies, all domains should be addressed if they are to be used as the basis for consistent, quality health promotion practice which can be recognised internationally and be accredited though a pan-European accreditation system. While these competencies were developed within a Pan-European context they may also be useful for health promotion competency development in other countries globally.

The competencies can also be useful to those working in other professional areas whose role includes health promotion (e.g., community health, health education) or those in the other sectors who are involved in partnerships to promote health or create healthy environments.

The matrix presented in Appendix 2 illustrates how the competencies can be used by health promotion practitioners at different levels of seniority or experience and also by other professionals whose role includes health promotion.

How can the CompHP Core Competencies be used?

The purpose of health promotion competencies is to provide a description of the essential knowledge, abilities, skills and values that are needed to inform effective practice. In this context some countries or organisations may use the Framework as a standalone document. However, within the context of the CompHP Project the core competencies are designed to provide a base of knowledge and skills for practice that will inform the development of Professional Standards for Health Promotion and a pan-European Accreditation Framework. An effective competency

---

5 For example, teachers, community development workers.
framework can provide a solid base for workforce development and has a wide range of potential useful applications across many areas.

Core Competencies have a key role to play in developing health promotion by (adapted from PHAC, 2008) (16):

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

Core Competencies may promote 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
- Forming the basis for accountable practice and quality assurance.

Core Competencies can benefit health promotion practitioners by:

- Ensuring that there are clear guidelines for the knowledge, skills and values needed to practice effectively and ethically
- Informing education, training and qualification frameworks to ensure that they are relevant to practice and workplace needs
- Assisting in career planning and identifying professional development and training needs
- Facilitating movement across roles, organisations, regions and countries through the use of shared understandings, qualifications and, where appropriate, accreditation systems based on the competencies
- Promoting better communication and team work in multidisciplinary and multisectoral settings by providing a common language and shared understanding of the key concepts and practices used in health promotion
- Helping to create a more unified workforce by providing a shared understanding of key concepts and practices
- Contributing to greater recognition and validation of health promotion and the work done by health promotion practitioners.
Core Competencies can benefit health promotion organisations by:

- Identifying staff development and training needs
- Developing job descriptions, interview questions and frameworks for evaluation and quality assurance
- Identifying the appropriate numbers and mix of health promotion workers in a given setting
- Assisting employers and managers to gain a better understanding of health promotion roles in individual workplaces and develop appropriate job descriptions.

In developing the CompHP Project it was recognised that for some countries and regions the core competencies may be all that is useful or appropriate for their specific practice or policy context. In these instances The CompHP Core Competencies for Health Promotion Handbook may be used as a ‘standalone’ document. However, within the context of the overall Project, the core competencies are designed to form the basis for the development of Professional Standards and a pan-European Accreditation Framework for Health Promotion as additional tools for health promotion workforce capacity development across Europe.

**Core Concepts and Principles Underpinning the CompHP Core Competencies**

The competencies are based on the core concepts and principles of health promotion outlined in the Ottawa Charter (18) and successive WHO charters and declarations on health promotion (5, 20-24). Health promotion is, therefore, understood to be ‘the process of enabling people to increase control over, and to improve, their health’ (18). Health promotion is viewed as representing a comprehensive social and political process which not only embraces action directed at strengthening the skills and capabilities of individuals, but also actions directed toward changing social, environmental and economic conditions which impact on health (25). Health is defined as ‘a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity’ (26). Health is further conceptualised as a resource for everyday life, emphasising social and personal resources, as well as physical capacities (18).

The CompHP Core Competencies are underpinned by an understanding that health promotion has been shown to be an ethical, principled, effective and evidence-based discipline (27, 28) and that there are well-developed theories, strategies, evidence and values that underpin good practice in health promotion (29).

The term ‘health promotion action’ is used in the core competencies to describe programmes, policies and other organised health promotion interventions that are empowering, participatory, holistic, intersectoral, equitable, sustainable and multi-strategy in nature (22) which aim to improve health and reduce health inequities.
CompHP CORE COMPETENCIES FOR HEALTH PROMOTION FRAMEWORK

The CompHP Core Competency Framework comprises domains of core competency which are illustrated in Figure 1. Ethical Values and the Health Promotion Knowledge base are depicted as underpinning all Health Promotion action detailed in the nine other domains. Ethical Values are integral to the practice of health promotion and form the context within which all the other competencies are practiced. The Health Promotion Knowledge domain describes the core concepts and principles that make health promotion practice distinctive. The remaining nine domains, including: Enable Change, Advocate for Health, Mediate through Partnership, Communication, Leadership, Assessment, Planning, Implementation, and Evaluation and Research, each deal with a specific area of health promotion practice with their associated competency statements articulating the necessary skills needed for competent practice. It is the combined application of all the domains and the ethical values which constitute the CompHP Core Competency Framework.

Figure 1: Illustration of CompHP Competencies Framework
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 prioritising the needs of those experiencing poverty and social marginalisation
- Addressing the political, economic, social, cultural, environmental, behavioural and biological determinants of health and wellbeing
- 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 programmes 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 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 which support empowerment, participation, partnership and equity as the basis for health promotion action
• The current theories and evidence which underpin effective leadership, advocacy and partnership building and their implication for health promotion action
• The current models and approaches of effective project and programme 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 which impact on health and their relevance for health promotion.

1. **Enable Change**

   *Enable individuals, groups, communities and organisations 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 which impact positively on health and reduce health inequities
   1.2 Use health promotion approaches which support empowerment, participation, partnership and equity to create environments and settings which 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 organisations 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 which 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 which impact positively 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 which 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, non-verbal, 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 organisations 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 which facilitate empowerment and participation (including team work, 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 mobilising and managing resources for health promotion action

5.6 Contribute to team and organisational 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, behavioural 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 which impact on 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 Mobilise, 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 programme 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.
GLOSSARY

The terms defined in this glossary are based on the references provided but are, in some cases, slightly reworded to make them more directly relevant to the CompHP Project.

**Advocacy**: A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme. Advocacy can take many forms including the use of the mass media and multi-media, direct political lobbying, and community mobilisation through, for example, coalitions of interest around defined issues (30).

**Assessment** (see also needs assessment): The systematic collection and analysis of data in order to provide a basis for decision-making (31).

**Capacity Building**: The development of knowledge, skills, commitment, structures, systems and leadership to enable effective health promotion. It involves actions to improve health at three levels: the advancement of knowledge and skills among practitioners; the expansion of support and infrastructure for health promotion in organisations, and; the development of cohesiveness and partnerships for health in communities (32).

**Collaboration**: A recognised relationship among different sectors or groups, which has been formed to take action on an issue in a way that is more effective or sustainable than might be achieved by one sector or group acting alone (33).

**Community Assets**: Contributions made by individuals, citizen associations, and local institutions that individually and/or collectively build the community’s capacity to assure the health, well-being, and quality of life for the community and all its members (34).

**Community Development**: Helping communities take control over their health, social and economic issues by using and building on their existing strengths. It recognises that some communities have fewer resources than others, and supports these communities (35).

**Competencies**: A combination of the essential knowledge, abilities, skills and values necessary for the practice of health promotion (Adapted from 9).

**Consensus**: This term means overwhelming agreement. The key indicator of whether or not a consensus has been reached is that everyone agrees they can live with the final proposal after every effort has been made to meet any outstanding interests. Most consensus processes seek unanimity, but settle for overwhelming agreement that goes as far as possible toward meeting the interests of all stakeholders (36).
Core Competencies: These competencies constitute the minimum sets 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 (10).

Culture: A socially inherited body of learning including knowledge, values, beliefs, customs, language, religion, art, etc. (37).

Delphi Method/Technique: A process used to collect and distil the judgments of experts using a series of questionnaires interspersed with feedback (38).

Determinants of health: The range of political, economic, social, cultural, environmental, behavioural and biological factors which determine the health status of individuals or populations (30).

Empowerment for health: A process through which people gain greater control over decisions and actions which impact on their health. Empowerment may be a social, cultural, psychological or political process through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision-making, and achieve political, social and cultural action to meet those needs. Individual empowerment refers to the individuals’ ability to make decisions and have control over their personal life. Community empowerment involves individuals acting collectively to gain greater influence and control over the determinants of health and the quality of life in their community (30).

Enable: This term means taking action in partnership with individuals or groups to empower them, through the mobilisation of human and material resources, to promote and protect their health. A key role for health promotion practitioners is acting as a catalyst for change by enabling individuals, groups, communities and organisations to improve their health through actions such as providing access to information on health, facilitating skills development, and supporting access to the political processes which shape public policies affecting health (30).

Equity / Inequity in health: Equity means fairness. Equity in health means that people’s needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity which result, for example in unequal access to health services, to nutritious food, adequate housing and so on. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life (30). See also: 
http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf
Ethics: The branch of philosophy dealing with distinctions between right and wrong, and with the moral consequences of human actions. Much of modern ethical thinking is based on the concepts of human rights, individual freedom and autonomy, and on doing good and not harming (35).

Health: A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Within the context of health promotion, health is considered as a resource which permits people to lead an individually, socially and economically productive life. The Ottawa Charter (18) emphasises pre-requisites for health which include peace, adequate economic resources, food and shelter, and a stable eco-system and sustainable resource use. Recognition of these pre-requisites highlights the inextricable links between social and economic conditions, the physical environment, individual lifestyles and health. These links provide the key to a holistic understanding of health which is central to the definition of health promotion (30).

Health Promotion: This term refers to the process of enabling people to increase control over, and to improve their health. Health promotion represents a comprehensive social and political process, which not only includes 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. The Ottawa Charter (18) identifies three basic strategies for health promotion:

- advocacy for health to create the essential conditions for health
- enabling all people to achieve their full health potential
- mediating between the different interests in society in the pursuit of health.

These strategies are supported by five priority action areas for health promotion:

- Build healthy public policy
- Create supportive environments for health
- Strengthen community action for health
- Develop personal skills, and
- Re-orient health services.

Health Education: Health education comprises planned learning designed to improve knowledge, and develop life skills which are conducive to individual and community health. 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 (30).

Healthy Public Policy: The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives by making healthy choices possible or easier and social and physical environments health enhancing (20).


**Inequity:** See Equity

**Leadership:** In the field of health promotion, leadership can be defined as the ability of an individual to influence, motivate, and enable others to contribute toward the effectiveness and success of their community and/or the organisation in which they work. It involves inspiring people to develop and achieve a vision and goals. Leaders provide mentoring, coaching and recognition. They encourage empowerment, thus allowing other leaders to emerge (33).

**Mediate:** A process through which the different interests (personal, social, economic) of individuals and communities, and different sectors (public and private) are reconciled in ways that promote and protect health. Enabling change in any context inevitably produces conflicts between the different sectors and interests. Reconciling such conflicts in ways that promote health requires input from health promotion practitioners, including the application of skills in advocacy for health and conflict resolution (33).

**Needs Assessment:** A systematic procedure for determining the nature and extent of health needs in a population, the causes and contributing factors to those needs and the resources (assets) which are available to respond to these (30).

**Partnership:** A partnership for health promotion is a voluntary agreement between individuals, groups, communities, organisations or sectors to work cooperatively towards a common goal through joint action (30) and (33).

**Right to Health:** In relation to health, a rights-based approach means integrating human rights norms and principles in the design, implementation, monitoring, and evaluation of all health-related policies and programmes. These include human dignity, attention to the needs and rights of vulnerable groups, and an emphasis on ensuring that health systems are made accessible to all. The principle of equality and freedom from discrimination is central, including discrimination on the basis of sex and gender roles. Integrating human rights into development also means empowering poor people, ensuring their participation in decision-making processes which concern them and incorporating accountability mechanisms which they can access (39).

**Settings for Health Promotion:** The places or social contexts in which people live, work and play and in which in which environmental, organisational and personal factors interact to affect health and wellbeing. Action to promote health in different settings can take different forms including organisational or community development or working on specific health related issues. Examples of settings for health promotion action occurs include: schools, workplace, hospitals, prisons, universities, villages and cities (30).
**Social Justice**: Refers to the concept of a society that gives individuals and groups fair treatment and an equitable share of the benefits of society. In this context, social justice is based on the concepts of human rights and equity. Under social justice, all groups and individuals are entitled equally to important rights such as health protection and minimal standards of income (33).

**Stakeholder**: Individuals, groups, communities and organisations that have an interest or share in an issue, activity or action (40).

**Strategies**: Broad statements that set a direction and are pursued through specific actions, i.e., those carried out in programmes and projects (34).

**Supportive Environments for Health**: Offer people protection from threats to health, and enable people to expand their capabilities and develop self-reliance in health (30).

**Teamwork**: Is the process whereby a group of people, with a common goal, work together to increase the efficiency of the task in hand. They see themselves as a team and meet regularly to achieve and evaluate those goals. Regular communication, coordination, distinctive roles, interdependent tasks and shared norms are important features (41).

**Values**: The beliefs, traditions and social customs held dear and honoured by individuals and collective society. Moral values are deeply believed, change little over time and may be, but are not necessarily, grounded in religious faith such as beliefs about the sanctity of life, the role of families in society, a protection from harm of children and other vulnerable people. Social values are more flexible and may change as individuals undergo experience and include, for example, beliefs about the status and roles of women in society, attitudes towards use of alcohol, tobacco and other substances (33).

**Vision**: A vision expresses goals that are worth striving for and incorporates shared health promotion ideals and values (34).

**Workforce Planning**: The strategic alignment of an organisation’s human resources with the direction of its planned service and business (41).
REFERENCES


APPENDIX 1

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APPENDIX 2

Figure 2 below (adapted from Shilton, 2008) (42) illustrates how the CompHP Core Competencies Framework can be used for different roles and levels of expertise. Those who are full time in health promotion regardless of level of experience are expected to have an understanding of all competency domains and statements. It is recognised that those using the CompHP Core Competencies Framework may wish to identify different levels of expertise for some or all of the competencies or to emphasise some competencies to a greater degree than others. For example, the core competencies could be used as the basis for developing more advanced competencies for practitioners working at senior management level in health promotion as illustrated by the deeper shading in the matrix.

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<tr>
<th></th>
<th>Entry Level</th>
<th>Experienced</th>
<th>Manager</th>
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<td>Practitioner</td>
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<td><strong>Health Promotion</strong></td>
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<td>Part of Role</td>
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<td><strong>Broader Intersectoral</strong></td>
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<td>Workforce</td>
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**Figure 2: Health Promotion Workforce**

The CompHP Core Competencies Framework can also be useful to those working in other professional areas for whom health promotion is part of their role (e.g. community health) and can inform the development of sub-sets of competencies for those who work in specific settings. The CompHP Core Competencies Framework are also a useful tool for those in the broader intersectoral workforce (e.g. teachers, environmental health officers, etc) who engage in promoting health in specific settings or as part of partnerships to promote health.
This publication arises from the project *Developing competencies and professional standards for health promotion capacity building in Europe (CompHP – project number 20081209)* which has received funding from the European Union, in the framework of the Health Programme. This publication has been produced under the contract with the Executive Agency for Health and Consumers. Its content is the sole responsibility of the authors and can in no way be taken to reflect the views of the Executive Agency for Health and Consumers or any other body of the European Union.