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Review

Has the Development of Health Promotion Competencies Made a Difference? A Scoping Review of the Literature

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Abstract

Introduction. Competency-based approaches have been developed in health promotion over the past four decades but, to date, there has been limited focus on the evaluation of their use and impact. In 2016, 5 years after publication of the CompHP Core Competencies Framework for Health Promotion, an evaluation of their use and impact across the health promotion community in Europe was initiated. As a first step in this process, a scoping review of the literature was undertaken which aimed to explore the current status of health promotion competencies, with a particular focus on developments in Europe and ascertain what evidence exists about the use and impact of health promotion competencies on practice, education, and training. *Method*. Searches of the electronic databases and gray literature were conducted between February 2016 and December 2017. The searches were limited to sources published in English between 2009 and 2017, which focused on health promotion competencies. *Results*. A total of 39 sources were identified for in-depth analysis, of which 26 were theoretical papers and 13 were papers reporting on empirical studies. Many of the sources presented health promotion competency frameworks or described their development. Some examples of the use of health promotion competencies were found but only two instances of their evaluation were identified. *Conclusions*. The review found few empirical studies on the implementation and use of health promotion competencies and highlights a lack of evaluation studies on their impact on practice, education, and training.

Keywords

competencies, competency frameworks, evaluation, health promotion, impact, literature review

Competencies have been developed in health promotion over the past four decades in some countries, while other countries are described as lacking the resources and capacity required to engage in their development (Battel-Kirk, Barry, Taub, & Lysoby, 2009; Dempsey, Barry, Battel-Kirk, & the CompHP Project Partners, 2011b).

While definitions of competencies differ, all refer to attributes such as knowledge, abilities, skills, and attitudes (e.g., Australian Health Promotion Association [AHPA], 2009; Battel-Kirk et al., 2009; Dempsey, Barry, Battel-Kirk, & the CompHP Project Partners, 2011a, 2011c; Health Promotion Forum of New Zealand [HPFNZ], 2012; International Union for Health Promotion and Education [IUHPE], 2009). Core competencies, a term frequently used in the health promotion context, are defined as the minimum set of competencies that constitute a common baseline for all health promotion roles (AHPA, 2009).

Much of the literature on health promotion competencies centers on the positive outcomes which are expected to ensue from their implementation. For example, competencies have been described as a critical component of developing and strengthening health promotion workforce capacity to improve global health in the 21st century, as a key to quality assurance of practice, education and training, and as a means of developing a shared vision of what constitutes the specific knowledge and skills required for effective and ethical health promotion practice (Allegrante et al., 2009; Barry, 2008; Barry, Allegrante, Lamarre, Auld, & Taub, 2009; Barry, Battel-Kirk, & Dempsey, 2012; Battel-Kirk, Dempsey, & Barry, 2018; Battel-Kirk et al., 2009; Dempsey et al., 2011a, 2011b, 2011c; IUHPE, 2009).

Other benefits that may accrue from implementing health promotion competencies have also been identified (e.g.,

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AHPA, 2009; Dempsey et al., 2011c), including that they may

- improve career planning and job mobility, recruitment and selection, and workforce development
- assist employers and managers to gain a better understanding of health promotion roles
- contribute to greater recognition and validation of health promotion and the work done by health promotion practitioners
- underpin future developments in health promotion training and systems of accreditation
- provide accountability to the public for the quality of health promotion practice

However, there is also reference to potentially negative consequences of using competencies in health promotion (e.g., Howat, Lower, James, & Shilton, 2001; Hyndman & O'Neill, 2012; Meresman et al., 2004), which can be summarized as that they may

- be restricting/reductionist/mechanistic/limiting innovation and therefore, not allowing for the dynamic nature of health promotion
- tend to undervalue professional judgment and experience

It has also been suggested that, as no methodology has been identified which links the development of competencies to the evidence base, what they reflect is not necessarily "best" or evidence-based practice. Other concerns include that developing and implementing competencies may be time consuming, complex, and costly (Battel-Kirk et al., 2009; Dempsey et al., 2011b).

Despite these conflicting views on health promotion competencies, little evidence has been gathered on their use, or to support claims about their impact. While recommendations have been made for their review and revision (e.g., AHPA, 2009; Battel-Kirk et al., 2009; Dempsey et al., 2011b, 2011c; HPFNZ, 2012), there is little or no reference to the need to evaluate if, and how competencies are used, the impact that they have on health promotion practice, education, and training, and whether they achieve the beneficial outcomes generally attributed to their implementation.

It was in this context that, 5 years after the publication of the CompHP Core Competencies Framework for Health Promotion (Dempsey et al., 2011c), it seemed timely to initiate an evaluation of their use and impact on practice, education, and training in Europe. This literature review was undertaken to inform that evaluation.

Method

The approach chosen for this review was that of a scoping review, as this was considered to best match the context of the review and the evaluation it will inform. Scoping reviews are deemed to be useful (Arksey & O'Malley, 2005; Colquhoun et al., 2014; Dault, Mossel, van, & Scott, 2013; Levac, Colquhoun, & O'Brien, 2010) in mapping a body of literature with regard to

- addressing exploratory research questions that aim to map the key concepts underpinning a research area and the main sources and types of evidence available, especially where an area has not been reviewed comprehensively
- identifying gaps in the existing evidence base.

Unlike systematic reviews, the scoping process does not necessarily include a quality assessment of the sources reviewed (e.g., Arksey & O'Malley, 2005; Colquhoun et al., 2014). This is of particular relevance in the current review as many of the sources included are from the "gray literature" for which there are no standardized measures of quality.

The scoping review followed the framework suggested by Arksey and O'Malley (2005) in

- defining the research question
- identifying relevant studies
- selecting studies using an iterative process
- charting the data using a descriptive approach
- collating and reporting results

Two key questions informed the review, based on Dault et al. (2013):

- What can the literature published since 2009 tell us about the current status of health promotion competencies, with a particular focus on developments in Europe?
- What evidence exists about the use and impact of health promotion competencies on practice, education, and training?

Based on these research questions, relevant sources were initially identified though an electronic search of the international literature undertaken between October and February 2016 and updated in December 2017. The databases searched included Scopus, Embase, Medline, PubMed, Science Direct, CINAHL and Cochrane, using the following search terms:

(a) Health Promotion OR Health Education OR Public Health AND competenc*[1] OR competency frameworks OR standards OR accredit* OR credential* OR register*
(b) Results from above AND evaluation and impact.

Sources in the gray literature were identified via Google using the search terms:

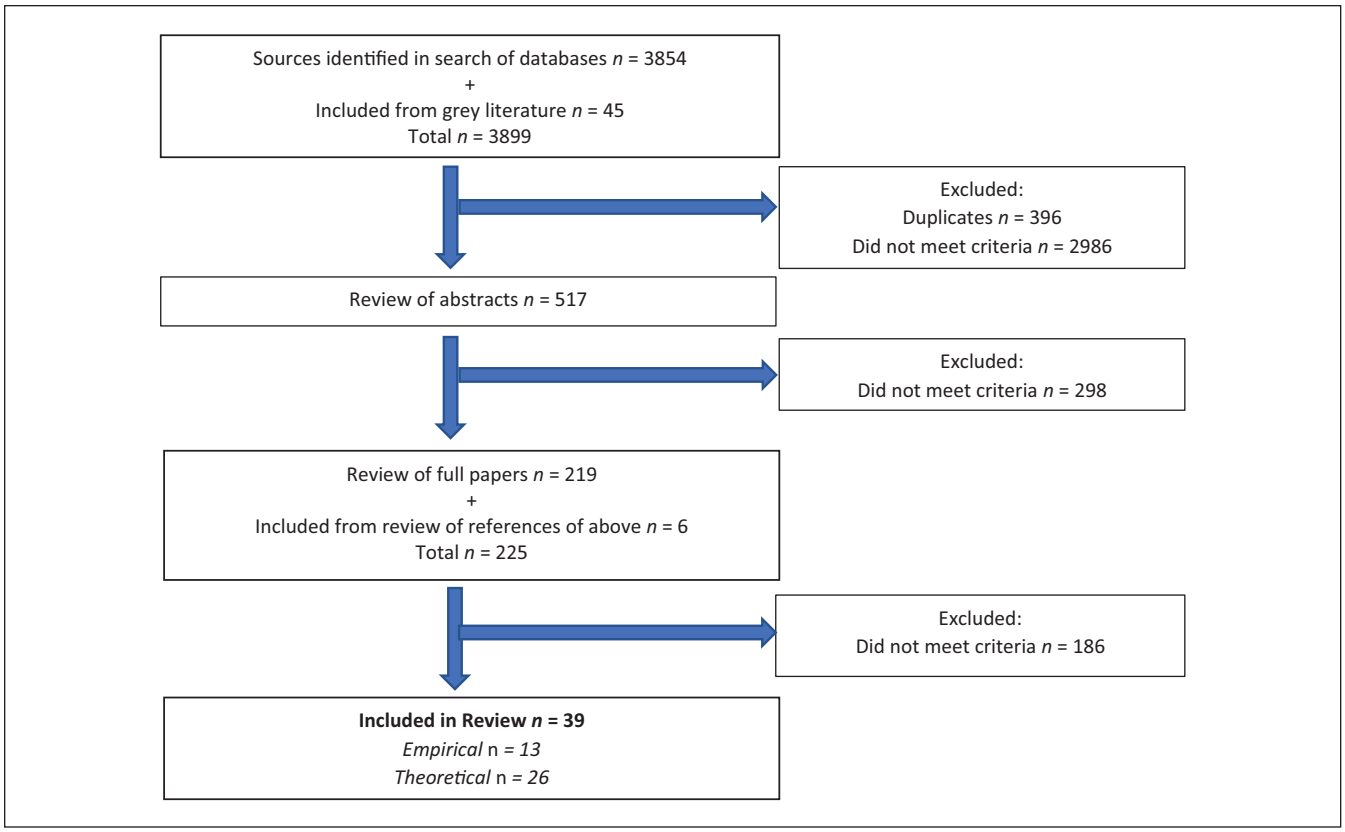

Figure 1. Search process and results.

(a) Competencies, standards, competency frameworks OR Health Promotion, Public Health and Health Education
(b) CompHP OR Health Promotion

Finally, the websites of health promotion, public health, and health education organizations were examined for references to competency-based developments and key informants within the health promotion community were asked to share pertinent sources.

The searches were limited to sources published in English between 2009 and 2017 and focused on the literature on competencies in health promotion, with public health and health education sources included where they contained specific reference to health promotion competencies. The initial focus of the search was on the European context; however, due to a paucity of Europe specific sources, the search was expanded to include relevant papers at the global level.

The criteria for inclusion of sources were that they must focus on the development and/or use and/or evaluation of health promotion competencies, while those focusing on a single aspect of competence (e.g., cultural competencies) or for use in a solitary context (e.g., in one academic program) were excluded.

Using this search strategy, all titles and abstracts retrieved were scanned for relevance, duplicates sources and those that did not meet the inclusion/exclusion criteria were removed (Figure 1) and the remaining full texts were analyzed. The analysis process comprised an iterative process of review and discussion involving both authors. The papers identified for inclusion were tabulated (Tables 1-4) with a descriptive review of their focus and/or findings. The included papers were grouped under the headings of "empirical" papers (i.e., those papers that present empirical data from primary sources and report on the methods by which the data were obtained) or "theoretical" papers (comprising those papers which were descriptive of key concepts and theories or contextual issues regarding the development, use, and evaluation of health promotion competencies).

Findings

The 39 sources included in the review comprised 26 theoretical papers (Tables 1-3), comprising six competency frameworks (Tables 1 and 2) and 20 discussion papers (Table 3), together with 13 papers reporting on empirical studies (Table 4). A total of 16 of the sources were published in the "gray literature" comprising six competency frameworks (Tables 1 and 2) and 10 reports (Contu et al., 2012; Dempsey

Table 1. Theoretical Papers: Current Health Promotion Competency Frameworks.

Title/scope	Rationale for development	Target audience	Competence level	Development process	References to/relationships with other health promotion and related sources
Core Competencies for Health Promotion Practitioners *AHPA (2009). Australia*	The development of an effective and sustainable health promotion workforce.	Health promotion practitioners	Entry	Builds on earlier development work (e.g., Howat et al., 2001).	Ottawa Charter (WHO, 1986)/other Health Promotion Charters WHO (2009, 2005, 2000, 1997, 1991); Public health competencies (PHAC, 2007; PHANZ, 2007).
Galway Conference Consensus Statement *IUHPE (2009). Global*	A competent workforce is a key component of capacity building for the future and critical to delivering on the vision, values, and commitments of global health promotion.	Health promotion practitioners, academics, researchers, employers, government, NGO policy decision makers	None defined	Consensus building with key international experts (Allegrante et al., 2009; Barry et al., 2009).	International competency developments (see Battel-Kirk et al., 2009); United Nations (2007); WHO Health Promotion Charters (2009, 2005, 2000, 1997, 1991, 1986); WHO (2006).
Health Promotion Competencies and Standards. *WHO SEARO (2010)*	To build capacity for health promotion practice across sectors, strengthen national capacity for effective health promotion and build a health promotion workforce with knowledge, skills, and attitudes required for effective practice in country-specific situations.	Health promotion practitioners and educators	Basic generic	Consensus at meeting of experts from academic institutions and practitioners.	Health promotion competencies (AHPA, 2009); Bangkok and Ottawa Charters for Health Promotion (WHO, 2005, 1986).
CompHP Core Competencies for Health Promotion *Dempsey et al. (2011c). Europe*[a]	The 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 workforce capacity across Europe.	Health promotion practitioners and providers of health promotion courses in Europe	Entry	Consensus building with the European health promotion community (Barry, Battel-Kirk, & Dempsey, 2012; Dempsey et al., 2011a).	Health promotion competencies (AHPA, 2009; HPFNZ, 2000); Ottawa/other WHO Health Promotion charters (WHO, 2009, 2005, 2000, 1997, 1991); Galway Consensus Statement (IUHPE, 2009); Public Health Competencies (PHAC, 2007).
Health Promotion Competencies *HPFNZ (2012). Aotearoa New Zealand*	To identify and define the behaviors, skills, knowledge, and attitudes that health promoters need to work effectively and appropriately.	Health promoters; others using health promotion as an approach	Three levels	Revision of earlier version (HPFNZ, 2000) plus consultations with workforce.	Galway Consensus Statement (IUHPE, 2009); health promotion competencies (AHPA, 2009; Dempsey et al., 2011c); Public Health Competencies (PHANZ, 2007); Health Promotion Charters (2009, 2005, 2000, 1997, 1991, 1986).
Pan-Canadian Health Promoter Competencies and Preamble. *HPC (2015)*	To respond to increasing demand for practitioners with the knowledge, abilities, skills, and values necessary to address increasing complexity of health issues, such as the burden of chronic diseases. Concern for health inequities and recognition of the importance of healthy public policies and creating supportive environments for health, also fueled their development.	Health promoters; those who manage and hire them; academic institutions providing health promotion education and training	Two levels	Consultations with health promotion workforce (Moloughney, 2015), building on earlier work (e.g., Ghassemi, 2009; Hyndman, 2007; Moloughney, 2006).	Ottawa Charter (WHO, 1986); health promotion competencies (Dempsey et al., 2011c); Public Health Competencies (PHAC, 2007).

Note. AHPA = Australian Health Promotion Association; WHO = World Health Organization; SEARO = South East Asia Region Organization; PHANZ = Public Health Association for New Zealand; PHAC = Public Health Agency of Canada; IUHPE = International Union for Health Promotion and Education; NGO = nongovernmental organization; HPFNZ = Health Promotion Forum of New Zealand.

[a]The original title of the CompHP Core Competencies Framework is used in this article and it is discussed within its original European scope. However, it should be noted that this framework is now known as the IUHPE Core Competencies Framework which, together with the IUHPE Professional standards, form the basis for the global IUHPE Health Promotion Accreditation System (Battel-Kirk, 2016).

Table 2. Competency Domains Mapped Across Current Health Promotion Competency Frameworks.

Australia (AHPA, 2009)	Galway Consensus Statement (IUHPE, 2009)	WHO SEARO (2010)	CompHP (Dempsey et al., 2011c)	New Zealand (HPFNZ, 2012)	Canada (HPC, 2015)
	Catalyzing change	Managing change; community capacity strengthening	Enable change	Enable	Building community capacity/ mobilization
	Advocacy	Advocacy	Advocate for Health	Advocate	Policy development and advocacy
Partnership building	Partnerships	Partnership building	Mediate through partnership	Mediate	Partnership and collaboration
Communication and report writing		Communication; use of appropriate technology	Communicate	Communication	Communication
	Leadership	Leadership teamwork	Leadership	Lead	
Needs or situational assessment	Assessment		Assessment	Assess	Situational assessments
Program planning; planning evidence-based strategies	Planning	Program management; planning and organization	Planning	Plan	Plan and evaluate health promotion action
Implementation	Implementation	Program management	Implementation	Implement	
Evaluation and research	Evaluation	Program management	Evaluation and research	Evaluate and research	Plan and evaluate health promotion
Knowledge competencies		Knowledge and comprehension of health promotion	Health promotion knowledge base	Knowledge base	Health promotion knowledge and skills
Twelve principles as the basis for the development of an ethical framework	Core values and principles noted as basis for competency domains	Ethical and professional practice	Ethical values (domain)	Values central to health promotion practice in New Zealand and globally	Core values and principles in preamble
Technology		Evidence-based practice; social marketing; healthy public policies; health promotion financing			

Note. AHPA = Australian Health Promotion Association; WHO = World Health Organization; SEARO = South East Asia Region Organization; IUHPE = International Union for Health Promotion and Education; HPC = Health Promotion Canada; HPFNZ = Health Promotion Forum of New Zealand.

et al., 2011a, 2011b; Gallardo et al., 2012; Hall, 2014; HPFNZ, 2004; Hicks, 2013; Moloughney, 2015; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; van der Zanden et al., 2012).

The theoretical papers reviewed (Tables 1-3) focused on health promotion competencies and related competency-based developments at global (Allegrante et al., 2009; Allegrante et al., 2012; Barry et al., 2009; Barry et al., 2013; Battel-Kirk et al., 2009; Dempsey et al., 2011b; Hall, 2014; Hauge & Hem, 2011; IUHPE, 2009; Shilton, 2009), regional (Battel-Kirk et al., 2015; Dempsey et al., 2011c; Mereu et al., 2015; Santa-María Morales et al., 2009; World Health Organization South East Asian Region [WHO SEARO], 2010), and national levels (AHPA, 2009; Ekenedo & Ezedum, 2013; Health Promotion Canada [HPC], 2015; HPFNZ, 2012; Madsen & Bell, 2012; Pinheiro et al., 2015), with three having a dual focus (Garista et al., 2015; Hyndman, 2009; Onya, 2009).

Nine of the papers reporting on empirical studies (Table 4) focused on the development of competencies (Barry, Battel-Kirk, & Dempsey, 2012; Dempsey et al., 2011a) and competency-based processes (Battel-Kirk & Barry, 2013; Battel-Kirk et al., 2012; Contu et al., 2012; Gallardo et al., 2012; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; van der Zanden et al., 2012) within the CompHP Project (Barry, Battel-Kirk, Davison, et al., 2012), all of which used multimethod approaches to reach consensus. Of the remaining empirical papers, one focused on developing competencies at national level (Moloughney, 2015) using consultative methods, while Burke et al. (2009) presented feedback on the Galway Consensus Statement (IUHPE,

Table 3. Theoretical Papers.

Author(s)/scope	Aim of paper	Key points/findings	Conclusions
Battel-Kirk et al. (2015). *Europe*	To describe the operationalization and piloting of the International Union for Health Promotion and Education (IUHPE) European Health Promotion Accreditation System.	• A governance structure was established, together with agreed policies and procedures for the Accreditation System. • Based on agreed structures and processes, a web-based application system was developed and managed at IUHPE headquarters. • During the pilot period, applications from 20 health promotion practitioners, 2 health promotion education programs, and 1 national accreditation organization were processed.	While recognizing the challenges, the overall positive feedback and the commitment demonstrated by the health promotion community form a constructive platform for the implementation of the IUHPE Accreditation System in Europe and internationally.
Garista et al. (2015). *Italy/Europe*	To explore the impact of an international online competency - based accreditation system on pedagogical models and strategies in higher education.	• The development of the CompHP competency-based health promotion standards (Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012) poses challenges for higher education institutions in Italy and elsewhere. • Resulting need to shift focus from defining learning objectives to identify teaching strategies and assessment measures which ensure that that students acquire the necessary competencies.	There is a need to engage in deep pedagogical reflection to ensure that higher education health promotion students acquire CompHP and other relevant competencies. Valid and reliable modes of assessment are required, not only for accreditation, but to ensure a stronger and more competent health promotion workforce.
Mereu et al. (2015). *Europe*	To investigate the European debate on, and perspectives for, professional development in the context of professional competencies in health promotion and public health.	• Similarities and differences between public health and health promotion at all levels in Europe, including in competency frameworks. • The professional status of those working in public health and health promotion characterized by wide diversity. • Health promotion is not recognized as a specific profession in several countries, professionals working exclusively on health promotion are extremely rare and training and practice embedded in public health.	Flexible competencies and accreditation systems should be developed that can empower and incorporate professionals and education providers. A flexible, synergic relationship will enable public health and health promotion professions to avoid unnecessary conflicts and to change, or cope, with the European professional and educational environment.
Pinheiro et al. (2015). *Brazil*	To report on possibilities and limits of using the CompHP Core Competencies (Dempsey et al., 2011c) in professional training in health in Brazil.	• The development of health promotion competencies internationally, in particular the CompHP Core Competencies, provides a context to discuss their development and use in Brazil.	While the CompHP Core Competencies were developed in Europe, they can be of great benefit to training in health promotion in Brazil.
Hall (2014). *Global*	To review the development of a competent global health promotion workforce, including a review of health promotion competencies.	• Developing health promotion competencies is a key element of building a competent workforce. • Similarities across competency frameworks globally. • New Zealand framework (Health Promotion Forum of New Zealand [HPFNZ], 2012) highlights cultural competence.	Developing competencies serves to ensure quality and enhance recognition of the health promotion workforce, they are vital in defining the knowledge required to practice effectively and ensure that practice reflects Health promotion principles and values.
Barry, Battel-Kirk, and Dempsey (2013). *Global*	To review the development of competency-based workforce capacity and the use of health promotion competencies to inform the implementation of effective action to address noncommunicable diseases (NCDs) globally.	• Developing capacity is universally recognized as a key strategy in tackling the burden of NCDs. • Existing competency-based frameworks provide a practical, action-oriented basis for workforce capacity building for targeting NCDs globally. • Core competencies can inform implementation of effective health promotion action on NCDs globally.	There is a need to develop workforce capacity for sustainable, ethical, and effective health promotion action to target NCDs at all levels—globally, regionally, nationally, and locally. The implementation of a core competency framework for health promotion practice and education can be a useful tool for workforce capacity development in this field.

(continued)

Table 3. (continued)

Author(s)/scope	Aim of paper	Key points/findings	Conclusions
Ekenedo and Ezedum (2013). *Nigeria*	To examine the need to develop competencies for health promotion practice in Nigeria, with reference to international competency development.	• Competencies are required to guide training programs and curriculum development to build and strengthen the workforce and the capacity of academic health promotion. • The experiences of other countries in developing competencies makes this easier for Nigeria.	Health promotion in Nigeria requires a synergistic approach, backed by a solid set of competencies for practice and education to change public health delivery. With international competencies as a guide, international agencies such should assist Nigeria in developing health promotion competencies.
Allegrante, Barry, Auld, and Lamarre (2012). *Global*	To report on global progress in core competencies and quality assurance for health education and health promotion since the Galway Consensus Conference (Allegrante et al., 2009; Barry et al., 2009; IUHPE, 2009).	• Progress has been made in developing competencies for health promotion globally. • Progress includes the CompHP Project in Europe and initiatives in North and Latin America, Australia, and New Zealand.	The Galway Consensus Conferences served as a catalyst in advancing the agenda on competency development, but work remains to be done to sustain the momentum to further catalyze workforce competency. This requires global commitment from all sectors at the highest levels.
Hyndman and O'Neill (2012). *Canada*	To consider the development of competencies in the context of debate on the professionalization of health promotion in Canada.	• Ongoing debate on the risks and benefits of developing competencies for health promotion in Canada. • Concerns that, if competencies are rigidly interpreted, they could curtail innovative practice and alienate other professions involved in health promotion.	The Canadian health promotion community has taken a cautionary stance on developing competencies, despite endorsement of the need to develop competency-based quality assurance mechanisms at international level.
Madsen and Bell (2012). *Australia*	To describe the use of health promotion competencies in curriculum development in higher education.	• The Australian Health Promotion Association (2009) competencies provide a useful basis for developing curricula. • Core competencies, while not a panacea, provide a framework, along with research, to help ensure that higher education institutions provide an appropriate nurturing ground for health promotion graduates.	Constructing curricula within the higher education sector is fraught with challenges and competing tensions. Using health promotion core competencies as the basis of curriculum models is one way of attempting to keep curricula coherent and relevant.
Van der Putten, Makone, and Chiriseri (2012). *South East Asia*	To detail how paradigm shifts in health promotion education in Southeast Asia can be fostered, with reference to international health promotion competency frameworks.	• International competency frameworks for health promotion provide a useful basis for comparison of Southeast Asia health promotion education with that in socioeconomic advanced regions.	The reorientation of health promotion creates the need for enhanced professional competencies and the development of competency-based education programs.
Dempsey et al. (2011b). *Global*	To review the international literature on health promotion competencies in the context of developing the CompHP Core Competencies Framework (Dempsey et al., 2011c).	• An emerging international literature on health promotion competencies. • Significant, but uneven, progress globally in developing competencies for health promotion, with some countries lacking resources to engage. • Health promotion considered an evolving field of practice in Europe. • Variable levels rate of health promotion capacity reflected the socioeconomic, cultural, and political contexts within the EU. • Commonalities identified across frameworks, most primarily designed for practitioners whose core function is health promotion and focus at entry level. • Few examples of a specialized health promotion workforce in Europe. • Relationships between public health and health education unclear in many countries in Europe.	Despite the challenges and the debates in the literature, the competency approach has generally been welcomed in relation to health promotion workforce capacity building. Ensuring that health promotion practice is informed by an agreed and defined body of knowledge, values, and skills, is critical to building a competent and well-prepared workforce in Europe. Developing general agreement on the core competencies for the health promotion is, therefore, key to building sustainable, effective practice for the future.

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Table 3. (continued)

Author(s)/scope	Aim of paper	Key points/findings	Conclusions
Hauge and Hem (2011). *Global*	To share findings from an analysis of the Galway Consensus Statement (IUHPE, 2009) by participants at a workshop held at the Sixth Nordic Health Promotion Research Conference in 2009.	• Limitations of the Statement identified. • The context of its use should be changed into a technology for disease prevention, to enabling dialog between contributors to health promotion with differing political and scientific ideals.	Despite its limitations, the Galway Consensus Statement has the potential to set a global agenda for health promotion education.
Allegrante et al. (2009). *Global*	To introduce the Galway Consensus Conference as a first step toward international collaboration on credentialing in health promotion and health education.	• The Galway Consensus Conference aimed to promote dialogue and an exchange of understanding among international partners regarding domains of core competency, standards, and quality assurance mechanisms in the professional preparation and practice of health promotion and health education specialists. • Consensus reached on Statement (IUHPE, 2009) including underpinning core values and eight domains of competence.	Broad agreement on professional standards can only emerge through energetic exchange of ideas on the issues, and standards must evolve continuously as the health promotion knowledge base expands and as we learn from practice.
Barry et al. (2009). *Global*	To describe how the Galway Consensus Conference achieved international consensus on core competencies for health promotion and health education.	• The conference was jointly organized by the IUHPE, the Society for Public Health Education, and the U.S. Centers for Disease Control. • A total of 26 international leaders in the field mainly from Europe and North America participated in the conference.	The conference was a first step toward reaching international accord on the competencies and quality assurance mechanisms necessary for developing health promotion workforce capacity.
Battel-Kirk et al. (2009). *Global*	To review the international literature on competencies in health promotion and related disciplines to inform the Galway Consensus Conference (Allegrante et al., 2009; Barry et al., 2009; IUHPE, 2009).	• Significant, but uneven, progress internationally in delineating health promotion competencies but many countries lack the resources to engage. • The literature focused mainly on presenting competency frameworks and how they were developed. • Most of the frameworks were primarily for use by health promotion practitioners, had similar domains and development processes. • Ongoing debate noted about the appropriateness and usefulness of defining competencies for health promotion. • Potentially negative impacts of competencies include that they may be restricting/reductionist/mechanistic. • Undervalue professional judgement and disregard values and principles. • Recommendations for developing international core competencies outlined. • An awareness of differing levels of health promotion development and of diverse cultural, social, and political contexts required in developing international competencies for health promotion.	Developing consensus on the core competencies in health promotion could serve as a useful basis for strengthening workforce capacity building and thereby contribute to advancing the quality of practice, education, and training globally. In identifying the way forward, it will be important to take account of current and future health promotion challenges, the diversity and trends within the health promotion workforce, and the rate of development of health promotion policy, knowledge, and infrastructure globally.
Hyndman (2009). *Global/ Canada*	To provide an overview of the process used to develop draft health promotion competencies in Canada and present the key similarities and differences between the draft Canadian competencies and those outlined in the Galway Consensus Statement (IUHPE, 2009).	• The competencies presented in the Galway Consensus Statement (IUHPE, 2009) build on an emerging international literature that includes a draft set of Canadian competencies. • The creation of draft health promotion competencies in Canada was fueled by concerns about the potential marginalization of health promotion and a national public health renewal process placing emphasis on competency development as a means of strengthening the workforce.	The Canadian experience with competency development in health promotion illustrates the ways in which health promotion practice is shaped by broader social and political contexts. It is hoped that the draft Canadian competencies will stimulate dialogue and an open exchange of ideas that will foster agreement on the parameters of effective health promotion practice.

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Table 3. (continued)

Author(s)/scope	Aim of paper	Key points/findings	Conclusions
Onya (2009). *Global/ African Region*	To discuss the potential impact of the Galway Consensus Conference and Statement (IUHPE, 2009) on health promotion capacity and competency development in the World Health Organization African region.	• Attempts to address the issue of competency and credentialing of health promotion and health education in Africa had yielded few results. • Most countries in the region had health promotion and education organizations which can benefit from the Galway Consensus Statement.	The Galway Consensus Conference has potential to positively affect building health promotion capacity and developing competencies in the African region. Educational planners, policy makers, and practitioners across the globe and in Africa are called on to provide a favorable environment for translating the Consensus Statement into real action.
Santa-María Morales et al. (2009). *Europe*	To provide an overview of recent developments in Europe, including those led by the IUHPE, in the context of developing a pan-European accreditation system.	• There is a growing and diverse health promotion workforce in Europe, but no overall body has responsibility for quality assuring standards of training and professional practice at the European level. • Developments in the United Kingdom, Estonia, and the Netherlands provide examples of competency-based systems in health promotion. • Differences in educational, practice, political, and resource situations reflect the complexity of developing a pan-European competency-based accreditation system that is flexible, relevant, and comprehensive.	Developing a pan-European accreditation system poses a significant challenge but also presents a unique opportunity to form a solid basis for building capacity and assuring quality for health promotion practice, research, and training across the European region.
Shilton (2009). *Global*	To discuss how the Galway Consensus Statement (IUHPE, 2009) can inform the development of competencies for health promotion globally.	• The Galway Consensus Statement (IUHPE, 2009) can advance professional standards in global health promotion by providing: • a common language by which health promotion can be communicated • a framework for building capacity in the health promotion • international consensus for consistency in university health promotion courses • A framework for credentialing in health promotion.	A vital application of the Galway Consensus Statement is to inform advocacy to ensure that health promotion is better resourced and prioritized by policy makers. Advocacy and communication are critical tools for highlighting the evidence, establish the policy fit and infrastructure requirements of health promotion and present solutions based on evidence.

Table 4. Empirical Articles.

Author(s)/scope	Aim of article	Research design	Key findings	Conclusions
Moloughney (2015). *Canada*	To describe the development and validation of the Pan-Canadian Health Promoter Competencies (HPC, 2015).	• Online survey (320+ respondents) • Workshops and teleconferences (150+ participants) • Webinars (200 participants) • Health promoter network (362 members)	• High levels of agreement with almost all draft statements, drafts amended to reflect feedback. • Challenges experienced in identifying and contacting health promoters to participate in consultations. • Participants considered health promotion practice to be underutilized and undervalued. • The cultural appropriateness of the competencies for indigenous populations should be confirmed.	The relevance of the competencies was demonstrated by their early use in informing a province-wide health promoter position profile, curriculum renewal in several universities and professional development events.
Hicks (2013). *New Zealand*	To report on an evaluation of knowledge and implementation of the Health Promotion Forum of New Zealand (HPFNZ; 2012) Health Promotion Competencies.	• Online survey emailed to the Health Promotion Forum's database, networks, and reference groups. • A total of 105 responses from a variety of organizations and individuals.	• Majority (88%) of respondents reported knowledge of the health promotion competencies. • Uses of the competencies included planning; implementing and evaluating health promotion action; informing students; providing a common language and shared understandings.	Changes associated with the implementation of the competencies (i.e., impact as defined for current study) included job descriptions and performance development plans and increased clarity of the health promotion role.
Battel-Kirk and Barry (2013). Battel-Kirk et al. (2012). van der Zanden, Battel-Kirk, Schipperen, and the CompHP Project Partners (2012).	To report on the development of a competency-based Pan-European Accreditation Framework for Health Promotion.	A phased, multimethod approach to achieving consensus included • review of health promotion/ other professional accreditation systems • Online survey emailed to 300+ contacts in 34 countries • Testing framework in practice settings in 12 countries • In-depth country specific studies in five countries • Testing in academic settings (12 courses from 13 countries) • National and European focus groups (165 participants) • Web-based consultation with the wider health promotion community.	• Overall support for the Framework, but reservations about the availability of the resources and capacity to support its implementation. • The relationship of health promotion and public health, and the fact that health promotion is not considered a separate function or discipline in some countries pose challenges for implementation.	The validity and robustness of the CompHP Accreditation Framework was founded on the extensive consultations undertaken in its development. The fact that it was based on the CompHP Core Competencies and Professional Standards, which were also developed through a consensus-building process and which have been endorsed at both national and European levels also added to the validity, robustness, and status of the Framework.

(continued)

Table 4. (continued)

Author(s)/scope	Aim of article	Research design	Key findings	Conclusions
Barry, Battel-Kirk, and Dempsey (2012). Dempsey et al. (2011a). *Europe*	To report on the development of the CompHP Core Competencies for Health Promotion Framework (Dempsey et al., 2011c).	A phased, multiple-method approach • Mapping of existing health promotion competency frameworks • Delphi survey (two rounds) with health promotion practitioners, educators, and policy makers (30 European countries) • Focus groups with health promotion experts and stakeholders (200+ informants) • Web-based consultation with health promotion stakeholders (54 responses) • Input from Project Partners and International Expert Advisory Group.	• Results from each stage of the consultation informed revision of the framework. • Feedback on the competencies was positive in all stages of the consultation.	The consensus-based process used in developing the CompHP Core Competencies drew on, and has added to, the global literature on competencies and their development in health promotion and related fields. The CompHP Core Competencies provide a resource for workforce development in Europe by articulating the necessary knowledge, skills, and abilities required for effective practice and as the basis for Professional Standards and an Accreditation Framework.
Contu, Sotgiu, and the CompHP Project Partners (2012). *Europe*	To report on the mapping of the CompHP Core Competencies (Dempsey et al., 2011c) to academic curricula and explore accreditation of educational and training in Europe.	Multiple methods approach • Participative workshop (12 education providers from 8 European countries) • Questionnaire mapping competencies and standards to modules of course curricula, with collection of objective data, for example, website, handbooks (13 courses of 12 providers).	• A total of 100+ providers of health promotion education and training identified in Europe. • Differing systems, courses titles, and awards in health promotion education. • Health promotion not a recognized/licensed profession in many countries. • CompHP Core Competencies (Dempsey et al., 2011c), already informing curricula of several public health and health promotion courses.	There were providers of health promotion education and training whose courses fulfill, or could fulfill with minor changes, the competency-based requirements for accreditation. Implementation of competencies, standards, and accreditation as the basis for curriculum development could result in quality assured education and the creation of a specific culture of health promotion in Europe.
Gallardo Martinez, Zeugma, Garcia de Sola, and the CompHP Project Partners (2012). *Europe*	To report on testing a draft competency-based Accreditation Framework in practice settings with a range of national agencies across Europe.	Multiple methods approach • Updating of a Scoping Study on health promotion training, accreditation and professional standards in Europe (Santa-María Morales & Barry, 2007; 13 participants from 12 countries)	• A majority of respondents reported that the Framework could be used in their country. • Practitioners working to promote health existed in most countries but not as main role. • Job titles varied, for example, public health, prevention/improvement/education.	Despite the potential barriers to the implementation of the Framework, the overall support expressed, and the many drivers for success identified in the consultation, bode well for the success of the Europe-wide competency-based quality assurance Framework for Health Promotion.

(continued)

Table 4. (continued)

Author(s)/scope	Aim of article	Research design	Key findings	Conclusions
		• Online consultations (38 responses from 23 countries) • Discussion groups/workshops (158 participants from 17 countries) • Country perspective studies (6 countries, 28 interviews)	• Health promotion often incorporated into other functions, mainly public health. • Specialized health promotion training available, but often part of other courses. • Lack of resources and infrastructure. • Health promotion not recognized as a separate function in some countries, few examples of specialized health promotion workforces. • Very few health promotion professional associations and these few had limited resources.	
Speller, Parish, Davison, and Zilnyk (2012); Speller, Parish, Davison, Zilnyk, and the CompHP Project Partners (2012). *Europe*	To report on the development of competency-based CompHP Professional Standards for Health Promotion.	Three consultation phases: • Electronic survey e-mailed to (300 respondents with 72 responses) • Workshop and focus groups (140 stakeholders from 19 countries) • Online questionnaire on the final draft of the Professional Standards (20 responses) • Total of 232 responses	• Positive feedback, for example, 85% considered the Standards appropriate for health promotion in their country. • Diversity in the workforce/relationships between public health and health promotion may hinder implementation. • Implementation should reflect labor markets/political buy in. • Limited educational capacity in Europe to support professional development. • Potential uses of the Standards included to recognize and support professionals; inform job descriptions; guide the development of teaching, interviews, and professional development; regulate workers; keep courses up to date and to quality standards and supporting the reestablishment of health promotion as an essential part of public health.	The CompHP Professional Standards provide a firm foundation for effective, ethical, and professional health promotion practice and were already influencing education and training programs and were being translated and discussed at country level in Europe and elsewhere. The overall responses demonstrated that there is an evident appetite for the CompHP Professional Standards, and for rising to the challenge of implementing them within and accreditation framework.
Burke et al. (2009). *North America and Global*	To presents comments from the field on the Galway Consensus Statement (IUHPE, 2009).	• Online survey posted on the Society for Public Health Education website • Invitations to comment sent to specific individuals in North America	• Support for, and agreement with, the Statement. • Suggestions to add domains and questions on definitions of practitioners and power relations.	Feedback indicated overall support for the Galway Consensus Statement (IUHPE, 2009).
HPFNZ (2004). *Aotearoa New Zealand*	To report on a review of the use, and future, of the New Zealand Health Promotion Competencies (HPFNZ, 2000).	Feedback from the health promotion workforce gathered through • Interviews • Workshops and focus groups • Questionnaire (39 responses) • Document analysis • Compilation of anecdotal comments • Specific consultations with Maori and Pacific practitioners	• 2500+ Copies in circulation. • Current users included public health units, public health nongovernmental organizations, education and training providers, ministry of health staff/self-employed consultants. • Current use included staff and strategic development; training; recruitment and retention; quality assurance and program development; drawing up job descriptions, developing service codes of ethics, resource allocation and discussion on service plans.	The competencies were considered to provide concrete evidence of the substance and breadth of health promotion, a useful and informative tool and a basis for developing professional standards. Interrelated contextual factors need to be taken considered in identifying ways to strengthen health promotion knowledge, skills, practice, and outcomes.

2009). Two studies (HPFNZ, 2004; Hicks, 2013) presented evaluations of health promotion competencies. One of these studies (HPFNZ, 2004) was included in the review, despite having been published before the agreed timescale, given the dearth of examples of relevant evaluations.

The sources reviewed are summarized in Tables 1 to 4, followed by presentation of key findings.

Current Health Promotion Competency Frameworks and Their Development

The health promotion competency frameworks reviewed (Table 1) were developed at global (IUHPE, 2009), regional (Dempsey et al., 2011c; WHO SEARO, 2010), and national (AHPA, 2009; HPC, 2015; HPFNZ, 2012) levels. All but one (WHO SEARO, 2010) of the frameworks were developed by health promotion professional associations.

The need for a competent workforce to meet current and future health promotion challenges and assuring quality in practice, education, and training were common themes in the rationales provided for developing the competency frameworks and in their core aims (Barry, Battel-Kirk, & Dempsey, 2012; Dempsey et al., 2011a, 2011c; HPC, 2015; HPFNZ, 2012; IUHPE, 2009; Moloughney, 2015; WHO SEARO, 2010).

Potential benefits or outcomes which may accrue from the implementation of competencies were also outlined in some frameworks (AHPA, 2009; Dempsey et al., 2011c). These benefits included improved career planning and job mobility, workforce and team development, and greater recognition and validation of health promotion.

In some instances, developing health promotion competencies was regarded as the first step in establishing professional standards (Barry, Battel-Kirk, & Dempsey, 2012; Dempsey et al., 2011a, 2011c; HPFNZ, 2004) and accreditation systems (Barry, Battel-Kirk, & Dempsey, 2012; Dempsey et al., 2011a, 2011c; IUHPE, 2009). However, it was recognized that, for some countries, competencies could be used as the "standalone" basis for quality assurance (Barry, Battel-Kirk, & Dempsey, 2012; Dempsey et al., 2011a, 2011c).

All the frameworks drew on previous experience of competency development in health promotion and related disciplines, identified though undertaking literature reviews on health promotion competencies (e.g., Battel-Kirk et al., 2009; Dempsey et al., 2011b) and/or revisions of earlier versions (e.g., AHPA, 2009; HPFNZ, 2012; Moloughney, 2015), which lead to significant cross-referencing. All frameworks also referred to at least one of the WHO health promotion charters or declarations (e.g., the WHO Ottawa Charter for Health Promotion, 1986). The European (Dempsey et al., 2011c), Canadian (HPC, 2015; Moloughney, 2015), and New Zealand (HPFNZ, 2012) frameworks were also informed by public health competencies (Public Health Agency of Canada, 2007; Public Health Association of New Zealand, 2007).

Of the frameworks reviewed, the Galway Consensus Statement (IUHPE, 2009) and WHO SEARO (2010) were elaborated through expert meetings. Those developing competencies in Australia (AHPA, 2009), Europe (Barry, Battel-Kirk, & Dempsey, 2012; Dempsey et al., 2011b, 2011c), New Zealand (HPFNZ, 2012), and Canada (HPC, 2015; Moloughney, 2015) used multimethod approaches focusing on consensus building across relevant health promotion communities.

The domains identified across the frameworks were largely similar, with many reflecting the strategies and action areas of the Ottawa Charter for Health Promotion (WHO, 1986). Differences were noted across the frameworks in the levels of expertise associated with the competencies, however, with levels ranging from "entry to practice" (AHPA, 2009; Dempsey et al., 2011c) and "basic generic" (WHO SEARO, 2010) to two (HPC, 2015) or three levels HPFNZ, 2012). The three levels of competence indicated in the New Zealand framework, for example, each comprise seven components and form a continuum from entry into the health promotion workforce to highly qualified experts. Dempsey et al. (2011c) note that there was much discussion in the development stage of the CompHP Core Competencies about their appropriate level. Thus, while it was agreed that the CompHP Core Competencies are at "entry level" (i.e., the level at which a practitioner enters practice), it was also noted that that they could provide the basis for developing more advanced competencies for practitioners working at senior management level in health promotion or inform the development of specialized competencies for those who work in specific settings.

The Use and Evaluation of Health Promotion Competencies

Theoretical Papers (Table 3). Madsen and Bell (2012) described how the health promotion competencies were used to guide curriculum development within higher education, while Garista et al. (2015) highlighted the challenges posed for educators in using competency-based frameworks in this setting.

Using current competency frameworks to inform future health promotion action was described by Barry et al. (2013) in the context of developing workforce capacity to address noncommunicable diseases globally. There was also reference to current frameworks underpinning action in (Allegrante et al., 2012) or informing discussion on, the development of competency-based initiatives in a number of countries and regions (e.g., Ekenedo & Ezedum, 2013; Pinheiro et al., 2015; Van der Putten et al., 2012).

Empirical Articles (Table 4). Evidence of the use of newly published competencies in academic settings was found in Canada (Moloughney, 2015) and Europe (Contu et al., 2012). Speller, Parish, Davison, and Zilnyk (2012) and Speller,

Parish, Davison, Zilnyk, and the CompHP Project Partners (2012) reported on the development of professional standards comprising the knowledge, skills, and performance criteria for the CompHP competency domains. The CompHP Core Competencies (Dempsey et al., 2011c) also formed the assessment criteria for an accreditation framework, which was developed using participatory, multimethod research processes (Battel-Kirk & Barry, 2013; Battel-Kirk et al., 2012; Contu et al., 2012; Gallardo et al., 2012; van der Zanden et al., 2012). Studies undertaken in New Zealand (Hicks, 2013; HPFNZ, 2004) indicated that health promotion competencies had been used by a broad range of practitioners, educators, and policy makers across a breadth of contexts and settings.

In terms of evaluation, Burke et al. (2009) reported that the Galway Consensus Statement (IUHPE, 2009) was well received by the health promotion community in North America. However, only two specific examples of evaluation were found (Hicks, 2013; HPFNZ, 2004). Hicks (2013) for example, presented findings from an online survey on knowledge and use of the New Zealand competencies (HPFNZ, 2012), which found that a majority of respondents had knowledge of them; that they were being used in a variety of contexts and that their implementation had changed practice. A review (HPFNZ, 2004) of an earlier version of the New Zealand competencies (HPFNZ, 2000) used a range of methods, including interviews and a questionnaire and reported changes in practice and policy linked to their implementation.

Contextual Factors Which Influence the Development and Use of Competency-Based Approaches in Health Promotion

Theoretical Papers (Table 3). A lack of resources and health promotion infrastructure was noted as hampering the development of health promotion competencies in many countries at a global level (Battel-Kirk et al., 2009; Dempsey et al., 2011b). In Europe, the diverse levels of health promotion capacity development were viewed as reflecting the diversity of social, economic, cultural, and political contexts across European Union Member States (Dempsey et al., 2011b; Santa-María Morales et al., 2009). Hyndman (2009) suggested that the Canadian experience with health promotion competency development illustrated the ways in which health promotion practice was shaped by broader social and political contexts.

Multiple references were found in the European context to a lack of health promotion capacity and resources, limited availability of specialized/dedicated health promotion workforces, and limited capacity in education, leadership, and support (e.g., Battel-Kirk et al., 2012; Battel-Kirk et al., 2015; Dempsey et al., 2011b; Mereu et al., 2015; Santa-María Morales et al., 2009). A lack of capacity was reported in the South East Asia Region (WHO SEARO, 2010), while in Brazil (Pinheiro et al., 2015), Nigeria (Ekenedo & Ezedum, 2013), and the African Region generally (Onya, 2009), health promotion education and training were described as limited or lacking.

The diversity of the health promotion workforce in terms of roles, job titles, and educational backgrounds was identified as both a driver for, and a potential barrier to, developing and implementing competency-based initiatives (Battel-Kirk et al., 2009; Dempsey et al., 2011b; Mereu et al., 2015; Santa-María Morales et al., 2009). Overlap between public health and health promotion workforces, and the development of public health and health promotion competency frameworks in Europe, with different approaches to health promotion were also noted (Mereu et al., 2015). Differing opinions on the professionalization of health promotion in the context of competency-based workforce development were also identified in Europe (Mereu et al., 2015) and Canada (Hyndman & O'Neill, 2012).

Empirical Articles (Table 4). Research undertaken in developing competency-based professional standards and accreditation in Europe also indicated a lack of health promotion capacity, resources, and specialized workforces, together with limited capacity in education, leadership, and support (Battel-Kirk et al., 2012; Contu et al., 2012; Gallardo et al., 2012; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; van der Zanden et al., 2012). A lack of resources and dedicated workforces were also documented in Canada (Moloughney, 2015) and New Zealand (HPFNZ, 2004), while the scarcity of health promotion professional associations was identified as being a limiting factor in developing competency-based initiatives in Canada (Moloughney, 2015) and Europe (Gallardo et al., 2012).

There was evidence that health promotion was not recognized as a specific profession and that exclusively health promotion roles were limited in many countries in Europe (e.g., Barry, Battel-Kirk, & Dempsey, 2012; Battel-Kirk et al., 2012; Contu et al., 2012; Dempsey et al., 2011a; Gallardo et al., 2012; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; van der Zanden et al., 2012). Moloughney (2015) reported that there were limited dedicated health promotion positions and health promoters were not recognized as designated health professionals in areas in Canada. Speller, Parish, Davison, and Zilnyk (2012) and Speller, Parish, Davison, Zilnyk, and the CompHP Project Partners (2012) reported ongoing debates on the professionalization of health promotion in the context of delineating professional boundaries and roles.

A lack of clarity about overlapping health promotion and public health roles and functions, linked to a potential for interdisciplinary tensions, were reported in Europe (Gallardo et al., 2012; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project

Partners, 2012). Concerns that health promotion could become marginalized within the public health agenda were reported to be a driver for developing health promotion–specific competencies in Canada (Moloughney, 2015).

The New Zealand Health Promotion Forum (HPFNZ, 2004) concluded that, in identifying ways to strengthen health promotion knowledge, skills, practice and outcomes in the context of competencies and competency-based standards, many interrelated contextual factors needed to be considered, including

- the status of, and trends within, the health promotion field and workforce
- organizational and management support for, and competence in, health promotion
- trends and developments in health policy and infrastructure
- opportunities for, and investment in, health promotion training and qualifications
- quality assurance trends and procedures

Other contextual issues identified as relevant to the development and implementation of health promotion competencies included their cultural acceptability and appropriateness to indigenous peoples (HPFNZ, 2004, 2012; Moloughney, 2015) and issues of language and translation (Barry, Battel-Kirk, & Dempsey, 2012; Battel-Kirk et al., 2012; Contu et al., 2012; Gallardo et al., 2012; Moloughney, 2015; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; van der Zanden et al., 2012).

Discussion

Many interesting aspects of health promotion competencies were identified in this review, not least the commonalities across the various frameworks. However, given that the review was undertaken to explore the use and impact of competencies in Europe, this discussion concentrates mainly on issues which are considered as being of most relevance to this focus.

The ongoing debate about the overall usefulness and appropriateness of competencies to health promotion practice, education, and training (e.g., Battel-Kirk et al., 2009; Dempsey et al., 2011b) is at the core of evaluating their use and impact. Those evaluating health promotion competencies must, therefore, attempt to develop methodologies that can capture evidence on both their positive and negative impacts. The evaluation process may become more complicated where competencies are defined at different levels within the same framework, for example, by necessitating the need for instruments that can capture the nuances of the continuum from "entry to practice" to "expert" level while measuring their overall impact.

Many of the sources reviewed suggest that contextual factors influence if, and how, health promotion competencies are developed, how they are used, by whom and to what end across all settings (e.g., Battel-Kirk et al., 2009; Battel-Kirk et al., 2012; Contu et al., 2012; Dempsey et al., 2011b; Gallardo et al., 2012; HPFNZ, 2004; Moloughney, 2015; Santa-María Morales et al., 2009; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; van der Zanden et al., 2012). These issues include levels of health promotion capacity, organizational and managerial support at country and health promotion practice and educational levels and factors in the wider environment, including health policy and levels of social and economic development.

The influence of these contextual factors is an important area of investigation in relation to the use and ultimate impact of health promotion competencies in health promotion practice, education, and training. This is particularly the case as all but one (WHO SEARO, 2010) of the current frameworks were developed by professional associations, while their implementation will require support and resources from, and recognition by, statutory and academic bodies at national level. Speller, Parish, Davison, and Zilnyk (2012) and Speller, Parish, Davison, Zilnyk, and the CompHP Project Partners (2012), for example, refers to the need for political "buy in" in implementing competency-based initiatives in health promotion. The actions required in the future, and the success of those used to date, to promote and champion support for their implementation should, therefore, be a focus when exploring the use and impact of health promotion competencies.

Workforce and capacity development and assuring the quality of health promotion practice, education and training emerged as the core themes in the rationales for, and overall aims of, the current frameworks (AHPA, 2009; Allegrante et al., 2009; Barry, Battel-Kirk, & Dempsey, 2012; Barry et al., 2009; Dempsey et al., 2011a, 2011c; HPC, 2015; HPFNZ, 2012; IUHPE, 2009; Moloughney, 2015; WHO SEARO, 2010). While some direct measures of progress toward these aims may be possible, the potential benefits of their use, which is detailed in some of the frameworks (AHPA, 2009; Dempsey et al., 2011c), may be useful in developing indicators of progress toward overall aims.

While there is a consensus in the literature that competencies are key to workforce capacity development, there are also suggestions that a lack of health promotion capacity may hinder their development and use (e.g., Battel-Kirk et al., 2009; Contu et al., 2012; Dempsey et al., 2011b; Gallardo et al., 2012; HPFNZ, 2004; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; Moloughney, 2015). It will be important, therefore, to understand how general levels of health promotion capacity at a country-level influence attitudes to, and the use of, competencies.

The fact that health promotion is not recognized as a distinct area of practice and that job titles and academic course titles may not include the term "health promotion" in some countries (Barry, Battel-Kirk, & Dempsey, 2012; Battel-Kirk et al., 2012; Battel-Kirk et al., 2015; Contu et al., 2012; Dempsey et al., 2011a, 2011b, 2011c; Gallardo et al., 2012; Mereu et al., 2015; Moloughney, 2015; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; van der Zanden et al., 2012) may blur perceptions of the importance and relevance of health promotion competencies across the diverse health promotion workforce. Empirical studies are, therefore, required to capture attitudes on their perceived relevance and usefulness across different systems, sectors, and settings.

Issues of professional identity and boundaries, including the ongoing debates about the professionalization of health promotion (Hyndman & O'Neill, 2012; Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012; Mereu et al., 2015) have relevance for the uptake of competencies. The reported confusion about roles and functions, and indications of possible tensions between the health promotion and public health professional communities (e.g., Speller, Parish, Davison, & Zilnyk, 2012; Speller, Parish, Davison, Zilnyk, & the CompHP Project Partners, 2012) is exacerbated by the fact that different concepts of health promotion have been applied in European health promotion and public health competency frameworks (Mereu et al., 2015). These findings indicate the need for sensitive exploration of how interprofessional tensions influence, and are influenced by, the use and impact of health promotion competencies, in order to support what Mereu et al. (2015, p. 33) describe as a "flexible, synergic relationship which will enable public health and health promotion professions to avoid unnecessary conflicts and to change or cope with the professional and educational environment."

The apparent dearth of empirical studies on the use and impact of competencies on professional practice and education in general, and in health promotion in particular, means that there are few exemplars for future evaluations. However, the studies undertaken in New Zealand (HPFNZ, 2004; Hicks, 2013) serve to demonstrate that such evaluations are feasible and can produce useful data to inform future implementation. Hicks (2013), for example, proved that valuable information on the use and impact of health promotion competencies can be gathered using a simple questionnaire and established that respondents could identify changes which they attributed to the implementation of competencies within a year of their publication.

Conclusions

This scoping review provides an overview of the current status of health promotion competencies and identifies examples of their development and use in the context of quality assurance in practice, education, and training globally. However, the review findings also clearly highlight a paucity of empirical studies examining how competencies are implemented and if, and how, they have resulted in changes in health promotion practice, education, and training. There are a few promising indications, however, from two studies undertaken in New Zealand that competencies have had an impact across different health promotion contexts and settings, giving an impetus for further investigation. In identifying a gap in the current knowledge base, the findings, therefore, emphasize the importance of undertaking empirical studies to explore whether and how health promotion competencies are being used in Europe and what impact they have had on practice, education, and training to date. The findings also highlight the importance of examining the key drivers and barriers to the implementation of health promotion competencies and the contextual factors which may influence their use and impact.

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Note

1. Truncation was used to broaden the search to include various word endings and spellings based on these word roots.

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