Perspectives on Terminology and Conceptual and Professional Issues in Health Education and Health Promotion Credentialing

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This article was prepared to inform the deliberations of the Galway Consensus Conference by providing a common and global reference point for the discussion of terminology and key conceptual and professional issues in the credentialing of health education and health promotion specialists. The article provides a review of the terminology that is currently employed across different countries in defining *health education* and *health promotion* as well as *health educator* and *health promotion specialist.* The terminology used to describe concepts in professional credentialing of health education and health promotion specialists and the scope of professional responsibilities of such specialists, including the terms *professional competencies, professional standards,* and *accreditation,* are also reviewed. Finally, key unresolved issues are identified and discussed from a global perspective. The article concludes that despite differences in terminology in the definitions of roles and responsibilities, health education and health promotion are conceptually more similar than different across countries.

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

Global interest in workforce development, capacity building, and quality assurance in health education and health promotion has increased during the past decade. Improving the quality of practice of health education and health promotion as a population health science is at the core of this interest. However, if we are to achieve the global improvement in health that has been called for in the *Ottawa Charter* (World Health Organization, 1986), the *Bangkok Charter* (World Health Organization, 2005), and the *UN Millennium Development Goals Report* (2007) as well as by the International Union for Health Promotion and Education, then a global expansion of a competent health promotion and health education workforce will be needed (International Union

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for Health Promotion and Education, 2007). In turn, this will require that the health promotion and health education profession identify what constitutes the core competencies, standards, and quality assurance systems that will contribute to global health in the 21st century.

The identification of competencies for professional practice has been the focus of research in many countries (Gilmore, Olsen, Taub, & Connell, 2005; Hyndman, 2007; McCracken & Rance, 2000; Melville, Howat, Shilton, & Weinstein, 2006; Meresman et al., 2006; Moloughney, 2006; Shilton, Howat, James, & Lower, 2003). This research has delineated the knowledge and skills required for health promotion and health education practice, which has implications for professional preparation, education and training, credentialing, and continuing professional development. In addition, competencies may be used as the basis for the development of standards and quality assurance mechanisms, such as the certification of individual practitioners and accreditation of academic professional preparation programs.

The history and context for understanding the roles of competencies, standards, and quality assurance in professional development, however, varies considerably around the world. There is clearly variation in the extent and nature of professional development not only in established professions such as medicine but also in public health and in the health education and health promotion professions across countries. Some countries, such as the United States, have evolved clearly defined career pathways and models of academic training and professional preparation programs for health promotion and health education specialists. In contrast, many countries in Europe and elsewhere do not embrace health promotion and health education as specialized areas of practice but rather have sought to encapsulate these functions under the broader umbrella of the multidisciplinary public health profession. Thus, the cultural variations in the roles of medicine, public health, and health promotion and health education in various countries have, in turn, influenced concepts of professional practice, professional preparation, and professional authority and autonomy.

This article was prepared to inform the deliberations of the Galway Consensus Conference by providing a common understanding of the terminology and key conceptual and professional issues in health education and health promotion credentialing

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from a global perspective. Due to the limitations of information readily available online or in the English-language professional literature, the article provides selected examples. First, we review the terminology used in selected countries in defining the terms *health education* and *health promotion* as well as *health educator* and *health promotion specialist.* Next, we briefly review the meaning and relevance of the terminology used to describe concepts in professional credentialing of health education and health promotion specialists. These include *professional competencies, professional standards,* and *accreditation.* We also identify some key issues that attend each credentialing concept.

TERMINOLOGY

The terms *health education* and *health promotion* have different definitions both within the United States and between the United States and other countries. To illustrate this point, Table 1 presents definitions of these terms from selected countries where information on terminology was readily available in the English-language professional literature or through the World Wide Web. Many countries embrace the World Health Organization definition of *health promotion,* which is drawn from the *Ottawa Charter* (World Health Organization, 1986). The *Ottawa Charter* has served as a guiding framework for the global practice of health promotion, outlining the core principles, concepts, and action areas. Two overarching questions are, How do the terms relate to one another? and, Are there more commonalties than differences in the ways that *health education* and *health promotion* are defined from an international perspective? The term *health promotion* is used widely in many countries as an overarching concept that encompasses health education as one of its implementation strategies alongside, for example, creating supportive environments and healthy public policy. In other countries, the term *health education* is also used to encompass these broader strategies, for example, in the United States and in countries in South America. Based on historical, cultural, and political considerations, there is a preference for the use of either the term *health promotion* or the term *health education* to identify professional practice in a particular country.

The definitions of the roles and responsibilities of the professionals who conduct health education or health promotion are also of interest. The health promotion workforce in many countries is drawn from a diverse range of disciplines and backgrounds (e.g., ranging from those with formal credentials in medicine and nursing to exercise physiologists or those with degrees in applied social science and education), many of whose practitioners may not have formal qualifications in the field (i.e., no professional preparation or postgraduate qualification in health promotion). This has given rise to the question, Who constitutes the health promotion workforce? A distinction is often made between health promotion specialists or designated health promotion professionals (i.e., those who have *health promotion* in their job title), and the wider health promotion workforce. The latter includes a range of other professionals and people who play key roles in promoting health in a diverse range of sectors such as schools, primary health care, and communities. Therefore, the definitions of the roles and responsibilities and related levels of knowledge and skills required for these different levels of practice are likely to differ considerably and need to be considered. To date, efforts to delineate competencies and standards, for example, in Australia, Canada, the Netherlands, and the United Kingdom, usually have been developed for health promotion specialists but have highlighted that these developments are not intended to exclude the wider health promotion workforce. In addition, in the United States, health education is a distinct profession that has been recognized by the

Table 1. Definitions of Health Education and Health Promotion Used in Selected Countries

Country	Terms Used	Definition
United States	Health education field	"A practice that uses multidisciplinary theories and behavioral and organizational change principles to plan, implement, and evaluate interventions that enable individuals, groups, and communities to achieve personal, environmental, and social health" (Joint Committee on Health Education Terminology, 2002, p. 6).
	Health promotion	"Any planned combination of educational, political, environmental, regulatory, or organizational mechanisms that support actions and conditions of living conducive to the health of individuals, groups, and communities" (Joint Committee on Health Education Terminology, 2002, p. 6).
		"The science and art of helping people change their lifestyle to move toward a state of optimal health . . . defined as a balance of physical, emotion, social, spiritual and intellectual health" (O'Donnell, 1989, p. 5).
Canada	Health promotion	"The process of enabling people to increase control over, and to improve their health. It not only embraces actions directed at strengthening the skills and capabilities of individuals, but also action directed towards changing social, environmental, political and economic conditions so as to alleviate their impact on public and individual health" (http://www.phac-aspc.gc.ca/ccph-cesp/glos-e-h-eng.html).
New Zealand (Health Promotion Forum of New Zealand)	Health promotion	"The process of supporting people to increase control over the factors that influence their health and quality of life. An important characteristic of health promotion is its focus on groups of people, either the whole population or specific subgroups. It places emphasis on changing the environment to enable behaviour to change. Health promotion draws upon principles of social change, physical change, policy development, empowerment, community participation, equity and health, accountability, building partnerships and alliances between groups" (http://www.hpforum.org.nz/page.php?7).
Iran (Iran University of Medical Sciences)	Health education	"The process of providing learning experience which favorably influences understanding, attitudes, and behavior relating to individual and community health" (http://www.iums.ac.ir/find.php?item=26.1999.2071.en).
	Health promotion	"The process of enabling people to increase control over and to improve their health . . . a mediating strategy between people and their environment, synthesizing personal choice and social responsibility" (http://www.iums.ac.ir/find.php?item=26.1999.2071.en).

(continued)

Table 1. (continued)

Country	Terms Used	Definition
World Health Organization, Regional Office for South-East Asia	Health promotion	"A process of enabling people to increase control over their health and its determinants, and thereby improve their health" (http://www.searo.who.int/en/Section1174/Section1458/Section2057.htm).
	Health education	"A process comprising of [*sic*] consciously constructed opportunities for learning and communication designed to improve health information, health literacy, health knowledge and developing life skills which are conducive to the promotion of an individual and community's health including that of the environment" (http://www.searo.who.int/en/Section1174/Section1458/Section2057.htm).

Table 2. Definitions of *Health Educator* and *Health Promotion Specialist*: United States and United Kingdom

Term	Country	Definition
Health educator	United States	"A professionally prepared individual who serves in a variety of roles and is specifically trained to use appropriate educational strategies and methods to facilitate the development of policies, procedures, interventions, and systems conducive to the health of individuals, groups, and communities" (Joint Committee on Health Education Terminology, 2002, p. 6).
Health promotion specialist	United Kingdom	A health promotion specialist helps people to improve and increase control over their health. They plan, ensure implementation of, and evaluate policies and strategies to promote health within a specialist setting, relating to a specific issue, or within a particular population (http://www.prospects.ac.uk).

U.S. Department of Labor (2008; Office of Management and Budget, 2009), with formal academic preparation programs at the baccalaureate, master's, and doctoral degree levels. Notwithstanding these differences among countries, there are similarities in the definitions of the terms *health educator,* as defined in the United States, and *health promotion specialist,* as defined in the United Kingdom, for example. Table 2, which presents these definitions, illustrates that although different terms are used, the definitions are quite similar.

Efforts to reach national consensus about terminology have been ongoing in the United States for more than 70 years (Joint Committee on Health Education Terminology,

Table 3. Credentialing Terminology Used in the United States

Term	Definition
Accreditation	A type of program credentialing by which an academic program in a college or university meets predetermined criteria (Taub, 1994).
Certification	A type of individual credentialing by which a nongovernmental agency recognizes an individual who has met specific qualifications, such as graduation from an accredited academic program, passing an examination, or having a certain amount of work experience (Taub, 1994).
Competency	"An ability to apply a certain specified skill in dealing with some defined amount of meaningful subject matter" (National Commission for Health Education Credentialing, Inc., 1996, p. 81).
Credentialing	A broad term including regulation of both individuals (licensure, registration, certification) and academic programs in colleges and universities (accreditation, program approval; NCHEC, SOPHE, & AAHE, 2006; Taub, 1994).
Licensure	A type of individual credentialing where a governmental agency regulates practice if specific requirements are met (Taub, 1994).
Professional development	"The process by which an individual engages in planned activities which enhance knowledge or reinforce skills. . . . Terms used to describe this activity, for example, include in-service training and continuing education" (AAHE, NCHEC, & SOPHE, 1999, p. 60).
Program approval	A form of program credentialing by which an academic program engages in a self-study with external peer review.
Registration (registry)	Another type of individual credentialing wherein a governmental or other agency maintains a list of individuals who have met specific guidelines (Taub, 1993, 1994).
Standard	"The predetermined level of performance at which a criterion will be considered met" (AAHE, NCHEC, & SOPHE,1999, p. 60).
Subcompetency	"A specific ability or skill subordinate to and expected to contribute to accomplishment of a competency" (National Commission for Health Education Credentialing, Inc., 1985, p. 120).

2002). Similarly, research to delineate the role of the health educator has been undertaken in the United States for many decades (Gilmore et al., 2005; Henderson & McIntosh, 1981; American Association for Health Education [AAHE], National Commission for Health Education Credentialing, Inc. [NCHEC], & Society for Public Health Education [SOPHE], 1999). The terms commonly used to describe concepts in professional credentialing in the United States are presented and defined in Table 3.

In the most recent research, the National Health Educator Competencies Update Project Model identifies competencies and subcompetencies for the professional practice of health educators (Gilmore et al., 2005; NCHEC, SOPHE, & AAHE, 2006). The subcompetencies are used as the basis for the national certification examination for the certified health education specialist (CHES) and as a framework for the preparation of health educators in institutions of higher education (NCHEC, SOPHE, & AAHE, 2006). To ensure quality in the academic professional preparation of health educators in the United States, a variety of accreditation mechanisms are available to academic institutions of higher learning (see Cottrell et al., 2009).

With regard to health promotion, there has been progress in a number of countries, including Australia, Canada, and New Zealand (see Battel-Kirk, Barry, Taub, & Lysoby, 2009), in defining a set of core competencies for practice. These developments, which share many common elements, have sought to delineate the specific and unique knowledge and skill set that constitutes effective health promotion practice within the context of multidisciplinary public health. Various frameworks have been used, employing different formats, terminology, and degrees of complexity. Thus, the challenge at the international level is to explore the possibility of producing a core set of competencies that is sufficiently broad enough to be relevant to a wide-ranging audience and robust and meaningful within specific cultural contexts at the regional or country level.

Within the European regional context, a recent scoping study on the development of health promotion training, accreditation, and professional standards in Europe (Santa-Maria Morales & Barry, 2007) found that there are marked differences across countries in terms of the development of training, the presence of designated health promotion positions, and the establishment of professional accreditation systems. There is also ongoing debate concerning the professionalization of health promotion and the extent to which formal specialization should be required for access to health promotion work. Some countries (for example, Estonia, the Netherlands, and the United Kingdom) however, have developed formal training programs and established accreditation and registration systems. The development of a pan-European system is currently being led by the International Union for Health Promotion and Education in the European Region with a view to establishing core competencies for the health promotion workforce across the diverse countries of the European region.

The global level presents an even more complex picture. The different cultural, social, economic, and political contexts in which health promotion is practiced at the national level around the globe, with diverse and dynamic local contexts, will influence the specific competencies and standards required for the health promotion workforce in different countries. Moreover, the different rates of development of health promotion infrastructure and capacity building at the national level across diverse countries and regions need to be fully considered when contemplating international developments and the building of consensus in this area. Nevertheless, there exists a core set of health promotion knowledge, values, and skills based on existing theory, research, and practice that should underpin good practice across these diverse settings. This is reflected to a large extent in current developments.

PROFESSIONAL COMPETENCIES

Efforts to identify professional competencies for the practice of health promotion and health education have been initiated in many countries. Australia (Howat et al., 2000; Shilton et al., 2002, 2003), Canada (Hyndman, 2007), Israel (Melville et al., 2006), New Zealand (McCracken & Rance, 2000), and the United States (Gilmore et al., 2005; Taub, Olsen, Gilmore, & Connell, 2008), as well as several countries in Europe (Meresman et al., 2006), have all successfully codified such competencies. These efforts have defined the professional skills and knowledge required for individuals working in health education and health promotion. In addition, recent efforts have sought to define distinctions in the levels of practice, for example, entry-level practice to advanced practice (Gilmore et al., 2005; NCHEC, SOPHE, & AAHE, 2006). (For an in-depth review of the international literature on current frameworks and core competencies, see Battel-Kirk et al., 2009.)

Key Issues

1. Is health education/health promotion a profession or a specialty area? In some countries, health promotion is a defined profession and/or a specialty area within multidisciplinary public health. In the United States, health education is considered a distinct profession. Consequently, these different workforce structures and perspectives influence the delineation of competencies for professional practice.

2. Are there different competencies for specialists versus other professionals who do health education or health promotion? Consideration is given to those who have primary responsibility for health education or health promotion (i.e., specialists) and those who have another primary role. For example, a nurse may be primarily a clinician who also is involved in health education or health promotion. The competencies required of a specialist may be more extensive than those required of others whose primary role is not health promotion or health education. The issue of whether there should be differentiation in requirements for different levels (or tiers) of practice and responsibility has been addressed by some countries but is still a matter of ongoing debate in others.

3. What impact does the identification of professional competencies have on capacity building and workforce development? The identification of professional competencies is perceived by many as providing a solid basis for professional preparation, training, credentialing, and continuing professional development (Battel-Kirk et al., 2009; NCHEC, SOPHE, & AAHE, 2006). However, although the identification of health promotion competencies is generally seen as having a useful role to play in strengthening practice, there are mixed views concerning the use of professional competencies for purposes of accreditation. Some health promotion professionals hold the opinion that the identification of competencies should not be perceived automatically as being part of, or leading to, accreditation of programs (Hyndman, 2007).

4. Is there a common core of competencies for the practice of health education and health promotion that can be agreed on globally? Differences exist among countries and regions of the world in how competencies are identified and organized (see Battel-Kirk et al., 2009). Although some may argue that there are too many differences to find common ground, a critical examination may reveal commonalities that can be agreed on globally.

PROFESSIONAL STANDARDS

The establishment of professional standards is important to enhance the quality of practice in any discipline or profession, including health education and health promotion. In the United States, a national credentialing system, administered by NCHEC, was established in 1988. NCHEC sets national standards for the practice of health education. This system includes a national certification examination that is competency based and a continuing education requirement that is designed to promote continued professional development for those certified. In the United Kingdom, there have also been advances during the past decade to develop professional standards (Department of Health, 2001; Healthwork UK, 2001; Skills for Health, 2006; Wright, 2007). Using these standards, a registration process was developed and implemented. The UK Public Health Register began operation in May 2003. (For a broader discussion of professional standards in the United States and the United Kingdom, see Speller, Smith, & Lysoby, 2009.)

Key Issues

1. How do standards contribute to promotion of the professional identity of health education and health promotion as fields of practice? Standards may be useful to define a field of practice and establish the role of individuals with an identified skill set. Some argue that setting standards may exclude individuals from practice in a field. For example, meeting standards requires resources that may not be available to individuals, organizations, or governmental entities.

2. Can country-specific capacity be improved by global agreements on professional standards? Based on the differences noted by country, it may be difficult to apply global agreements on professional standards in the local context. On the other hand, having global agreements on professional standards may provide a useful reference point in developing standards within the local context.

3. What is the role of professional societies, government, and the public in setting standards? The role of professional societies, government, and the public varies among countries. To set standards, involvement of key stakeholders is essential. Some argue that government must play a key role. Others see the role of professional societies as key. Similarly, the involvement of the public is viewed as important.

4. Does the health of the public improve when there are standards of professional practice? Evidence is needed to determine whether the health of the public is improved when there are standards of professional practice. It is argued that standards attest to an individual's knowledge and skills (NCHEC, 2008). However, the impact of professional standard setting on the quality of practice and consequently on the health of the public has yet to be determined.

ACCREDITATION

In the United States, a variety of accreditation processes are now in place and available to academic programs in colleges and universities to enhance the quality of professional preparation (Cottrell et al., 2009). Many of these processes are voluntary but provide standards for the academic professional preparation of health education and health promotion professionals. Recent efforts in the United States have sought to establish a unified system of accreditation for academic professional preparation programs in health education (Allegrante et al., 2004). The development of accreditation mechanisms in Europe has been reviewed by Santa-Maria Morales et al. (2009), showing that most European countries are either at a very early stage in this process or have not even started. Accreditation of academic programs is not a high priority in all countries, including the United States. In some countries, for example, the identification of competencies for professional practice is not linked to accreditation of academic programs.

Key Issues

1. Should accreditation of academic professional preparation programs be voluntary or mandatory? In many professions, accreditation of academic professional preparation programs is mandatory. Graduation from an accredited program is required to practice. In health promotion and health education, where accreditation of academic

programs does exist, the process is mostly voluntary. It is argued that accreditation contributes to the improvement of academic programs. On the other hand, participating in accreditation is costly and time consuming.

2. What should be the role of government, professional societies, and independent agencies in accreditation? There is great variation country by country concerning the role of government, professional societies, and independent agencies in accreditation. To avoid conflict of interest, independent agencies may be responsible for accreditation. In some instances, government or professional societies may take the lead in establishing and operating accreditation systems.

3. How do the changing economic realities facing higher education affect the consideration of accreditation and the burden on faculty of multiple accreditations? In times of limited economic resources for higher education and more demands on faculty, it is argued that accreditation may not be a reality and have lower priority. On the other hand, accreditation may be useful in identifying quality programs to support decisions when resources are limited.

4. Does accreditation result in a uniformity of programs that may be detrimental to the creativity and individuality of academic programs? Accreditation is intended to improve the quality of academic programs. Some argue that the process results in the uniformity of programs and stifles the individuality of academic programs. Others argue the opposite, that accreditation allows for each program to define itself within a set of accreditation guidelines.

CONCLUSION

Our review of the publicly available information on terminology from around the world shows that despite variation in terminology and distinctions in definition, *health education* and *health promotion* are conceptually more similar than different across countries. Many key issues about reaching international consensus on core competencies, agreeing on professional standards within and across countries, and finding ways to move toward cross-national accreditation processes and frameworks still remain unresolved. Continued discussion of these issues on a global basis will be necessary if the profession is to identify and establish common ground on which to advance the global practice of health promotion and health education.

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