ASPHER'S EUROPEAN PUBLIC HEALTH CORE COMPETENCES PROGRAMME

Philosophy, Process, and Vision

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Foreword

The Association of Schools of Public Health in the European Region, ASPHER, exists to support its members in their efforts, individually and collectively, to strive for, and to achieve, excellence in public health education. ASPHER`s decision in 2006 to embark on the creation of a system of core competences designed to be appropriate for public health education and training, and for senior public health professionals engaged in public health practice, whether this be service work, teaching, or research – for many, a combination of more than one of these - followed various similar attempts elsewhere around the world. As population health status, health systems and public health systems as well as educational traditions vary across countries and over time, ASPHER however aimed at developing lists of competences based on European experiences, as expressed by the European schools of public health, by representatives of European ministries of health, and by public health workforce representatives.

The results were presented in ASPHER`s provisional lists of competences published in 2007 and 2008, and have since then been refined in order to increase precision and consistency. This time-consuming process – intended to result in the demarcation of a whole profession - has included the integration of further experience from various workshops and from more discussions with and comments from ASPHER members, the majority of whom have stated repeatedly that the development of lists of competences should have the highest priority. Moreover, the lists have to be implemented among ASPHER members, public health workforces and their employers, and they should be revised and further developed over time, as according to the nature of future public health challenges.

This short publication outlines the philosophy, the principles and methods, and the process applied to achieve what has been done thus far. Results are important, but the process is no less so. The development of lists of competences represents a continuous process, in which experiences from previous phases are crucial. Thus, publication in 2011 of the current ASPHER lists is not the end of the process. Preparation and refining of lists of public health competences needs to be a continuous process - so as to meet the needs of the populations we serve, and those of changing public health systems and workforces - so a sustainable means of ensuring this must be identified as one of the current priorities for ASPHER.

We are confident that the ASPHER lists of competences will facilitate a general rise in the standard of public health practice across Europe, and also enable a standardisation of MPH course curricula. There will in due course be many other benefits, including the use by employers of

competences needed in specific job descriptions; indeed, a version of the ASPHER competencies designed to be relevant to employment is already planned.

Paris and Maastricht, October, 2011

Antoine Flahault
President, ASPHER

Helmuth Brand
President-Elect, ASPHER

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1. Competence: the concept and its uses in public health

To coincide with the publication of two comprehensive, revised lists of European public health core competences [1,2], this report is intended to provide the reader with a brief introduction to the public health core competences programme of the Association of Schools of Public Health in the European Region (ASPHER), initiated in 2006 [3], with a focus on its philosophy, the methods used for its organisation, and the vision we hope it may inspire.

From the etymological point of view, the word *competence* originates from latin *competentia*, suitability, fitness, which in turn originates from *competere*: be suitable, be fit for, composed by *con-* , with or together, and *petere*, strive for, ask for [4]. Competence is defined as "condition of being capable" or "ability" [5], and as "A specific range of skill, knowledge, or ability" [6]. The concept is applied in various sciences and disciplines, including psychology and developmental psychology, law, economics, biology – and public health. As related to behaviour and cognitive development, *'It is important to make a distinction between the knowledge and skills a child possesses, called competence, and the demonstration of that knowledge in actual problem-solving situations, called performance'* [7].

In the context of ASPHER's European core competences programme, the competence concept includes *knowledge* as well as *skills.* Further subdivision has been applied based on the components of the main structure of the field – the science and art of public health [1,2]:

1. Methods in public health;
2. Population health and its social and economic determinants;
3. Population health and its material - physical, radiological, chemical and biological - environmental determinants;
4. Health policy; economics; organisational theory and management;
5. Health promotion: health education, health protection and disease prevention;
6. Ethics.

Originally, the last category was termed *'Cross-sectional themes, including strategy making, ethics, other themes'* [3], but as the refinement process developed, it became apparent that most themes could be allocated to the more specific chapters 1-5. Also the phrasing of the headlines of other chapters have been slightly modified since the first version of the lists.

The structure in itself reflects the cross-disciplinarity of the sciences involved in public health, and it is intended in principle to be exhaustive. Moreover, this structure is comparable to the structure applied in the list of core competences developed by the Association of Schools of Public Health

(ASPH) in the U.S.A. [8], reflecting that the fundamental concepts and approaches to consideration of the structure of the discipline of public health are rather similar, notwithstanding the fact that the strategies utilised for development of lists of competences have varied. Moreover, a rather simplistic model with few core competences – only ten in most chapters – were intended in the case of the ASPH list, whereas the lists developed by the Faculty of Public Health in the UK (9) include more detailed competence concepts and, accordingly, many more competences than are to be found in the ASPH list [8]. Regarding the methodology used for the collection of competences, and for their organisation and application, ASPHER by design chose a simple categorisation, as outlined above, but potentially with an unlimited number of competences, i.e. a number defined by the challenges identified from population health and health systems, and, accordingly, the tools needed to meet those challenges. Recently, we compared the strategies applied for the development of lists of competences in the UK, the US and in Europe by ASPHER [10].

The UK, US and European lists are not the only public health competence lists, but all over the world there have been a series of initiatives to establish lists of competences applicable either to public health as a whole, or to a part of it [10]. Most lists of competences developed thus far reflect mainly the individual level, whereas less attention has been paid to combinations of challenges and functions associated with competences defined at other organisational levels. Philosophies have also varied as regards how general competences might continue to be valid as defined (or not) across time and place; philosophies have also varied as regards the number of competences considered to be desirable, and regarding the extent to which theme and procedure-specific competences might be considered to be acceptable. Philosophies have also varied as regards the nature of the process of competence identification, for example, whether an authoritative, 'top-down' approach, or an ownership-sharing, 'bottom-up' process, are deemed to be the more appropriate [10].

In relation to public health challenges and, consequently, also to their associated public health activities, lists of public health competences serve a variety of key functions, which will apply as appropriate to each *organisational level of action* [10:]

- *Community, regional, national and European levels*
  Taken as a whole, the public health competence profile of a community, a region, or a nation must match public health functions, and thus reflect responses to the public health challenges confronting the community, region, or nation, etc., at a particular time, whether related to:

(1) The population's health, or

(2) The structure, functioning and economy of the public health system, public health functions and intervention programmes, or

(3) The interaction between these two dimensions *(1 & 2 above)*.

In other words, relevant competence profiles will vary across geographical locations, and, as population health as well as health systems evolve and change over time, so must competence profiles.

- *Institutional level*

  Demands for specific profiles of competences at the community, regional, national and European levels should be reflected in the delegation of functions to specific public health institutions and intervention programmes, and thus in the competence profiles presented by these institutions and interventions. In other words, relevant competence profiles should reflect both the structure and functions of public health systems and their initial and further development, as they exist at any particular location and point in time.

- *Group level - external delineation of the profession*

  Taken as a whole, competence profiles and thus lists of competences should reflect, in a transparent manner, both the types of challenges that the community expects members of the profession to be able to meet, and thus also the corresponding job functions which they will be expected to perform in a developed public health system, at any particular location and point in time.

- *Individual level*

  In public health practice, individual competence profiles will be associated with individual job roles, whether in general as members of the profession or at specified institutions. Accordingly, in public health education and training, competence profiles may be general, level specific (e.g. defined by bachelor, master or Ph.D. levels), or specialised by theme. Moreover, they may be, at least to some extent, time and place specific. Educational programmes should signal the competences achieved by taking the programme and its individual parts, and a series of testing procedures should ensure that each graduate has achieved a relevant number and quality of required competences.

Whether or not defined at community, regional, national or European levels, or at the institutional level, the group level, or the individual level, competences should be concretely observable – 'measurable' – so that *performance* at any of these levels can be evaluated with relative ease.

Mostly at the individual and group levels, it is likely that the use of lists of competences will be relevant for:

- Standard setting and curriculum development in public health education;
- Standardisation of public health training and practice across Europe;
- Use as indicators of completion of stages of training;
- Role definition and standardisation of public health job descriptions;
- Matching candidates to public health job vacancies;
- Easing mobility of public health professionals across borders, e.g. in the European Union (EU);
- Policy, strategy and interventional programme development.

Competences have to be appropriate and meaningful both to decision makers and to public health workforces, and also in an educational and research context.

As an expression of its utility in meeting public health challenges – challenges in population health as well as in health systems development - the list must link identifiable practical competences to professional activities in the public health services by use of a strategic model: ' The Public Health Cycle´ – with 5 mutually interacting stages:

Stage 1. Problem identification/community analysis/situation analysis;
  a. Population health and its contexts;
  b. Intervention systems;
Stage 2. Selection of targets and identification of target groups;
Stage 3. Selection of intervention;
Stage 4. Implementation of intervention;
Stage 5. Follow-up and evaluation.

Each and every one of these stages includes a set of concrete functions and tasks, and thus each demands its own defined sets of competences to be expected of the public health professional responsible for carrying out each such function in an appropriate way. To facilitate the production of an overview of competences needed in defined contexts, it may be appropriate firstly to select a population health challenge (e.g. lung cancer; cardiovascular disease; road traffic accidents), secondly to propose an intervention (tobacco control legislation or campaigns; food content

regulation or nutritional advice; change of road construction; etc.), and then, thirdly, to derive the necessary functions and their underlying competences in each of the appropriate stages.

This approach and process should provide a rational basis for the estimation of the investments needed in public health and in public health capacity development, in order to be able to meet population health and health systems challenges, both at present and in the future. Lists of competences and their relationships to the nature of the wide variety of challenges and interventions should play a key role in this process.

When initiating the European core competences programme, it was acknowledged that - owing to differences in population health and in health systems, and because of the need to develop co-ownership among the schools in order to support the implementation of the lists – it would not be appropriate simply to adopt a list of competences from any other part of the world. Rather it was essential that we in Europe had to identify and implement our own list-development process.

The basic philosophy underlying the collection of ideas for the initial competence list was that a relevant starting point would be provided by the schools of public health themselves; they should be asked about what were their teaching objectives, expressed in terms of intellectual and practical competences – representing respectively knowledge and skills. Within ASPHER, this was identified as a 'bottom-up-process'. It would also be necessary that competences should be discussed with decision makers, public health practitioners and other stakeholders, not least including the wider public health community in Europe, in order to ensure as far as possible the relevance, comprehensiveness, and utility of the competences [3, 10, 11].

2. The initial phases of ASPHER's core competences programme

The core competences programme was initiated by ASPHER in 2006 by the establishment of a management structure including six working groups, each being responsible for the collection of competences within its own respective field corresponding to the structure of the lists, as previously mentioned [3].

Academic staff at all member schools were invited to contribute, and volunteers were allocated to these groups. In total, nearly 100 staff members participated, by sending in suggestions for the emerging list. Other sources of inspiration were existing lists, finally resulting in two gross lists, one collected and developed during the first phase [3], with an expanded list being compiled by the end of the second phase [11].

The plan was an initial three-year programme with three phases:

1. *June-October 2007:* Development, by ASPHER members, of provisional lists of competences – a mapping exercise;
2. *November 2007-September 2008:* Further development of lists of competences in cooperation with public health stakeholders and after taking account of specific public health functions;
3. *October 2008 and onwards:* Further inclusion of more competences; refinement and clarification of those listed, and removal of duplication from the lists; classification of competences where possible, as according to the field of application, etc.

Acceptance by ASPHER members was sought by various means, including discussions at ASPHER's Deans' and Directors' Retreats in May or June of each year, at the annual conferences, and continuously amongst members.

The dialogue with decision makers and public health practitioners was supported by two international conferences, *The First European Conference on Core Competencies in Public Health Education*, 10-11 April, 2008, at Aarhus University, Aarhus, Denmark [12]. and *The* Sec*ond European Conference on Core Competencies in Public Health Education*, 30 October, 2008, at Ecole des Hautes Etudes de Santé Publique (HESP), Paris, France. This latter conference was included as a component activity associated with the French Presidency of the European Union Council of Ministers that year.

All European ministries of health were invited to send representatives to these two conferences, and thus, at the Aarhus conference, 27 countries were represented. The conference itself produced additional competences, which were then included in the Phase 2 Report [11] published just before, and discussed at the Paris conference.

Also presented to the Paris conference was a report of the first two pilot workshops, organised so as to facilitate communication about the new competence list with public health workforce representatives [13]. It was decided to identify common public health problems which would necessarily have to be addressed by public health workforces across Europe. Scenarios (mainly, but not only, appropriate to the "Health Promotion" section of competences) were identified, which related to public health nutrition and to problems related to misuse of alcohol. As it was planned that the workshops should be relevant to all levels of the wider public health workforce, there were two scenarios relating to each type of issue: two concerning development of relevant strategic plans for a city or for a region, and two concerned with "ground-level" type public health interventions, e.g. planning community gardens to be tended by local children. These workshops were held in Maribor, Slovenia, and in Carluke, Lanarkshire, Scotland – two communities with very different cultures. The workshops also demonstrated that such "testing" of competences with workforces was highly viable, and they themselves resulted in some useful recommendations; it was noteworthy that very similar recommendations were made at each of these geographically and culturally separated workshops. These also demonstrated that such activities generated other useful communication between representatives of public health academic institutions and workforce representatives [13].

It therefore became clear that workshops of this kind, to which all relevant public health stakeholders could be invited, would constitute a very useful means of providing useful information for development and refinement of competences. Further workshops organised along broadly similar lines were later held in Turin and Belgrade, and the recommendations of all these workshops was fed into subsequent competence refinement procedures. It has been accepted within ASPHER that there will be a long-term continuing need for such workshops, etc., and more have been planned.

3. Collecting and refining lists of competences

The basic philosophy underlying the development in 2006-8 of the first two published lists of public health core competences [3,11] was that they should reflect the overall ways of thinking in European schools of public health, to reflect their educational programmes: what they might aim to include, in terms of knowledge and skills, or, in other words, in terms of intellectual or theoretical competences and practical competences. Thus far, the process was strongly reminiscent of a mapping and classification exercise, which might be seen as somewhat analgous to the method of the work of the Swedish natural scientist Carl von Linné (1707-78), who collected flowers in the meadows, brought them home, observed them, established an empirically based classification; eventually this enabled him to classify flowers and to develop theories about their specific qualities.

Accordingly, the first two lists of European public health core competences, published in 2007 and 2008, present the first comprehensive empirically-based vision of how the minds of public health academic staff of European schools operate when they consider how best to meet public health challenges, whether associated with population health or with health systems, and whether related to public health practice or to research. Consequently, they were in charge, on the basis of their own ideas, of the process whereby they themselves could identify what should be the learning objectives to be achieved and therefore the competences to be demonstrated, as a result of their own educational programmes. Moreover, in an entirely empirical manner, these two first lists also reflect the first comprehensive picture of a public health profession, as defined by its identified competences, which in turn have been defined as according to the specific tasks and roles identified by themselves as members of that profession. Moreover, representatives of European ministries of health at the two conferences in Aarhus and Paris [11]. generally also supported this vision as presented by the schools, as the two lists were very thoroughly discussed at these conferences.

It should be noted that, partly on account of wide recognition of the complexity of public health work in general, no constraints were imposed regarding the number, type or phrasing of competences which might be listed. It was indicated merely that the competences should simply reflect the tools thought necessary to meet the demands to observe, understand, and evaluate public health challenges, and to determine and implement the most appropriate interventions chosen to deal with them. However, the competences should also demonstrate understanding of the dynamics of population health and of health systems, and of the importance of such an understanding for the satisfactory development of new interventions. It was indicated that, at this stage, each tool thus identified should be allocated to a very simple logical structure, characterised

by only two axes: the type of competence (whether intellectual or practical), and to which domain (i.e. one or another of six chapters) the competence should be allocated .

Moreover, taking account of the complexity of public health and its dependence on time, geography, social and material living conditions, culture and other factors, the original phrasing of individual competences by academic staff was in general accepted in the editorial process, on the basis that later scrutiny would refine the text and eradicate unnecessary overlaps of content. This respectful and gentle editorial line resulted inevitably in a fair number of overlaps, when suggested competences were combined in lists [11]. The amount of overlap obviously demanded tolerance on the part of the average academic reader. This transitional phase was however a necessary step to allow for the development of the present simplified and structured lists [1,2] to be based on the experiences and traditions of the schools of public health themselves and of public health decision makers so far involved in the process.

The question of how best to transform the raw lists into simplified ones was solved by application of the "law of parsimony" to these initial lists, thus demonstrating their conversion into a clear logical structure, with a minimum of overlap between and within chapters. Based upon the basic principles of the discipline of public health, and of its sub-disciplines, further sub-classification of the material was performed, and it was evident that some chapters would have to be further subdivided. This did not suffice, and what was additionally required was a period of hard and intense work on detailed study of the list of competences, and on removal of unnecessary words. Every clause was checked to ensure that each and every meaning remained intact in spite of the condensation processes. Precise terms had to be selected and less precise concepts were replaced by more focussed ones.

Another task was to develop the possibility of combining competences in different chapters, so that it might become possible to visualise a more cross-disciplinary, possibly holistic, approach. Deliberately attempts have been made not to be repetitive, but, on account of the profoundly cross-disciplinary nature of public health, it is inevitable that competences will be relevant in different areas of public health theory and practice. For example, competences defined in the methods section of a list are always bound to be applicable elsewhere. Accordingly, readers are invited to apply combinations of competences appropriately within their own research, teaching and practice.

So, in this third phase of the European core competences programme we have refined and increased the precision of definitions and concepts used, deemed to be appropriate for public health professionals of all kinds involved in higher levels of public health employment, whether in service work, teaching or research.

On accounts of its nature, ASPHER is concerned primarily with development of public health education, training and research in Europe, and accordingly its first priority has been identified as the need to use defined competences to inform the educational activities of its member organisations.

Thus, the present lists [1,2] represent the end of a programmatic phase, the aim of which was the concentration and refinement of the list produced on the basis of reactions from the schools and from a wider audience, and we are fully and equally responsible for the editing processes we have adopted. This phase has taken time, not least because it has been ambitious, aiming at not only the theoretical characterisation of an entire profession, but also at making this characterisation itself instrumental, in this way providing a basic justification for lists of competences themselves.

4. ASPHER members and the core competences programme

ASPHER members – schools of public health - have ownership of the process of the development of their lists of public health core competences. ASPHER members have supported, participated and contributed actively in various ways, offering their invaluable expertise to be used in this important process:

- ASPHER members took the decision, in 2006 and 2007, that a core competences programme was a high priority, and that such a programme should to be started;
- These members participated broadly and in large numbers in the original working groups, and they carried out the management of these groups, which delivered the basic material for the lists and for their further development;
- Over the years, the core competences programme has been repeatedly discussed at annual General Assemblies; at specific workshops at Annual Conferences; at annual Deans' and Directors' Retreats;
- Representatives of ASPHER member schools contributed to and participated in the conferences held in Aarhus and Paris, 2008;
- During spring 2011, a first edition of the new refined lists were circulated to ASPHER member schools for comment and discussion at the Deans' and Directors' Retreat in Belgrade in May 2011, following which considerable efforts were taken to ensure that the content and thinking behind each comment was included in the lists;
- ASPHER member schools have organised and participated in workshops for dialogue on competences and their relevance in the face of prevalent public health challenges, held so as to involve public health decision makers, practitioners, and school staff members, etc.

ASPHER member schools have repeatedly, e.g. in two Delfi processes, rated the development of lists of competences as their top priority amongst all of the Association's activities. In accordance with this, we consider and hope that the present refinement stage should be a prelude to a more widespread and continuous developmental process in the future.

5. The dialogue with the wider public health community

From the academic and educational point of view, lists of competences may be said to have a Janus-like nature: it does not suffice only to look inwards, into academic programmes for education and research. The link to the 'outer world' is indispensable, if the lists of competences are to represent the real needs of population health and health systems. This does not mean that non-academic stakeholders should be expected to decide the precise structure and content of lists of competences; indeed, in the end it is the responsibility of the schools that "real life" public heath challenges, and the appropriate responses to these, are translated into applicable learning targets for practice, education and research. Moreover, if the schools do not provide their students with tools appropriate to current public health challenges – whether in practice or research - their existence will not be justifiable. Accordingly, dialogue with other public health stakeholders is not only necessary but essential, and should be organised appropriately and continued on a permanent basis. Perhaps this should be seen as the birth of a new, important, and much-needed tradition.

ASPHER's European conferences involving ministries of health, and ASPHER's first workshops, at which competences from the emerging lists were discussed and tested for relevance, comprehensiveness, and appropriateness, as perceived by other public health stakeholders, especially by workforce representatives, have already been described above. As these exercises had proved to be so useful as components of the overall competences programme, it was decided both to plan more workshops in the future on a more systematic basis, and to try to experiment with the methods that might be used in workshops to promote effective dialogue between stakeholders about competences, both individually and collectively, and about related matters.

Those ASPHER member schools that had expressed interest in involvement in the competences project were divided, on a pragmatic basis, into four (north eastern, south eastern, south western, and north western) zones of Europe, in the hope that it might be possible to encourage the organisation of workshops, on a regular basis every year, in each of the zones. The expectation and hope was that individual schools would take the initiative to arrange workshops, to which they would invite local public health stakeholders (especially workforce representatives), at which a chosen set of competences would be discussed and reviewed, with reports on recommendations for any changes, etc., sent in to ASPHER. A leader for each of the sectors was identified.

Moreover, in 2011 it was decided that these ASPHER workshops might benefit from new thinking on methods for their organisation, as might be provided from other European health organisations, so both the European Health Management Association (EHMA) and EuroHealthNet accepted an

invitation to collaborate on workshops in Madrid, Kaunas, Maastricht and Izola. Close collaboration has also been established with The European Public Health Alliance (EPHA), which already was organising a series of public health capacity development workshops, mainly in central Europe, providing further opportunities for communication on the competences programme in workshops in various European towns.

Finally, the crucial collaboration with WHO Europe has been strengthened, especially since a workshop on public health capacity development, associated with WHO Regional Committee 61 in Baku, September 2011, was organised by ASPHER and EPHA at the invitation of WHO. ASPHER's competences programme is also being supported by the European Commission.

It is also the intention to encourage increased recognition of, and potential support for, ASPHER`s competences programme by arranging meetings with senior civil servants and ministers in European capitals, such as one held in Budapest in September 2011; further such meetings are planned in other capitals.

6. Implementation and future governance arrangements

Irrespective of the extent to which this development of a list of competences has sought to reflect the ideas of pubic health schools, policy makers and practitioners, and notwithstanding our best efforts to follow the basic programme principles, the ultimate "success" of this and subsequent lists will however depend on the extent to which they are implemented and used. As previously stated, it is anticipated that this use will be, e.g.:

- By public health schools (of various types) in their development of educational programmes;
- For schemes designed to evaluate public health degree courses, which might operate at regional, national, or European levels;
- For monitoring and evaluation of progress made by public health students and trainees;
- By public health students and trainees themselves, in their efforts to achieve the appropriate knowledge and skills that are required of them;
- By defining roles and by standardisation of public health job descriptions;
- By policy makers when considering public health challenges and how they should be met, in terms of organisational structures, strategies and policies; and
- By everyday practitioners planning whatever may be required to improve the level of health of local populations, for which they are responsible.

A shared understanding of core competences is crucial for planning and functioning at all organisational levels, i.e. the community, regional, national and European levels; the institutional level; the group level (external delineation of the profession); the individual level. This means that the implementation process should involve not only schools of public health but also a wider, "external" audience. The implementation process in all its aspects needs to be carefully planned, monitored and evaluated, and active participation from all stakeholders is fundamental. Core competences represent an indispensable, central tool and concept from a theoretical as well as practical perspective.

Continuation and further development of activities already described is planned, including:

- Workshops and other discussion fora at ASPHER events;
- Collaboration with WHO Europe and the EU Commission;
- Workshops with dialogue between decision makers, service workers and school representatives;

- National "master classes" and European conferences involving ministries of health and other high level decision makers as well as the WHO and the EU Commission;
- Collaboration with significant public health NGOs operating across Europe, such as, EPHA, EHMA, EuroHealthNet, and EUPHA;

Further new initiatives will also be crucial for the further development of both academic and service components of the developing European public health profession:

- Establishment of a European body to advise on public health capacity development generally, including on the continuing adjustment of the general lists of core competences; all such development work will require identification of the public health strategies needed to address all prevalent health challenges at European, national, regional and local levels, and then accordingly to link the appropriate competences required to address these challenges, and to list these competences; this body should also encourage new initiatives, for example the construction of more specialised lists, such as one designed to assist employment; others perhaps to be health phenomenon, health promotion or management centered, or geographicallty defined; etc.;
- Establishment of a European body for monitoring the progress, including towards the achievement of public health degrees, of training in European public health students and trainees, i.e. a body for testing the performance of students;
- Coordination with the newly established European Accreditation Agency, taking into account that the accreditation process will include assessment of the institutional achievement of selected – but not necessarily all - core competences, dependent upon the type of educational programme;
- A continued, strong advocacy process, based on widespread expert communication; some potential vehicles for such a process have been described in previous chapters.

References

[1] Birt C, Foldspang A. European Core Competences for Public Health Professionals (ECCPHP). ASPHER Publication N° 5. Brussels: ASPHER, 2011.

[2] Birt C, Foldspang A. European Core Competences for MPH Education (ECCMPHE). ASPHER Publication N° 6. Brussels: ASPHER, 2011.

[3] Foldspang A (Ed.). Provisional Lists of Public Health Core Competencies. European Public Health Core Competencies Programme (EPHCC) for Public Health Education. Phase 1. ASPHER Series N° 2. Brussels: ASPHER, 2007.

[4] Den Store Danske Encyclopædi (The Danish Encyclopedia). Copenhagen: Gyldendal, 1998.

[5] Collins English Dictionary. London: HarperCollins Publications, 2005.

[6] TheFreeDictionary; www.thefreedictionary.co/competence; extracted 14th October 2011

[7] Encyclopedia Britannica; www.britannica.com; extracted 2nd October 2011.

[8] Cahoun JG, Ramiah K, Weist EM, Shortell SM. Development of a Core Competency Model for the Master of Public Health Degree. Am J Public Health 2008;98:1598-1606.

[9] Public Health Skills and Career Framework. Multidisciplinary/multi-agency/multi-professional. London: Public Health Resource Unit, 2008.

[10] Birt C, Foldspang A. The Developing Role of Systems of Competences in Public Health Education and Practice. Public Health Rev 2011;33:134-47.

[11] Foldspang A (Ed.). Provisional Lists of Public Health Core Competencies. European Public Health Core Competencies Programme (EPHCC) for Public Health Education. Phase 2. ASPHER Series N° 4. Bruxelles: ASPHER, 2008.

[12] Report from the First European Conference on Core Competencies for Public Health Education, 10-11 April, 2008, Aarhus University, Aarhus, Denmark. Brussels: ASPHER, 2008.

[13] Whittaker PJ, Pegorie M, Read D, Birt C, Foldspang A. Do academic competencies relate to 'real public health practice'? A report from two exploratory workshops. Eur J Public Health 2010;20:8-9.

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ASPHER PUBLICATIONS AND ASPHER-RELATED PUBLICATIONS

BIRT C, FOLDSPANG A. ASPHER'S EUROPEAN PUBLIC HEALTH CORE COMPETENCES PROGRAMME: PHILOSOPHY, PROCESS AND VISION. ASPHER PUBLICATIONS NO 7. BRUSSELS: ASPHER, 2011.

BIRT C, FOLDSPANG A. EUROPEAN CORE COMPETENCES FOR MPH EDUCATION (ECCMPHE). ASPHER PUBLICATINS NO 6. BRUSSELS: ASPHER, 2011.

BIRT C, FOLDSPANG A. EUROPEAN CORE COMPETENCES FOR PUBLIC HEALTH PROFESSIONALS (ECCPHP). ASPHER PUBLICATIONS NO 5. BRUSSELS: ASPHER, 2011.

FOLDSPANG A (ED.). PROVISIONAL LISTS OF PUBLIC HEALTH CORE COMPETENCIES. EUROPEAN PUBLIC HEALTH CORE COMPETENCIES PROGRAMME (EPHCC) FOR PUBLIC HEALTH EDUCATION. PHASE 2. ASPHER SERIES N° 4. BRUSSELS: ASPHER, 2008.

GOODMAN J, OVERALL J, TULCHINSKY T. PUBLIC HEALTH WORKFORVCE CAPACITY BUILDING. LESSONS LEARNED FROM 'QUALITY DEVELOPMENT OF PUBLIC HEALTH TEACHING PROGRAMMES IN CENTRAL AND EASTERN EUROPE'. ASPHER SERIES N° 3. BRUSSELS: ASPHER, 2008.

FOLDSPANG A (ED.). PROVISIONAL LISTS OF PUBLIC HEALTH CORE COMPETENCIES. EUROPEAN PUBLIC HEALTH CORE COMPETENCIES PROGRAMME (EPHCC) FOR PUBLIC HEALTH EDUCATION. PHASE 1. ASPHER SERIES N° 2. BRUSSELS: ASPHER, 2007.

FOLDSPANG A, LOUVET T, NORMAND C, SITKO SJ (EDS.). ASPHER 40TH ANNIVERSARY. 1966-2006. ANNIVERSARY BOOK. ASPHER SERIES N° 1. SAINT-MAURICE: ASPHER, 2006.
FOLDSPANG A, LOUVET T ET AL (EDS.). VADEMECUM, THE EUROPEAN MASTER OF PUBLIC HEALTH (EMPH). SAINT- MAURICE: ASPHER, 2005.

LA MEJORA DE LA CALIDAD Y LA ACREDITATIÓN DE PROGRAMAS DE FORMACIÓN EN SALUD PÚBLICA, UN PROYECTO CONJUNTO, FUNDACIÓN MERIEUX —ASPHER 2000-2001. VALENCIA: ESCUELA VALENCIANA DE ESTUDIOS DE LA SALUD: ARTES GRAFICAS, 2004.

BURY J, GLIBER M. QUALITY IMPROVEMENT AND ACCREDITATION OF TRAINING PROGRAMMES IN PUBLIC HEALTH, FONDATION MÉRIEUX-ASPHER JOINT PROJECT 2000-2001. LYON: EDITION FONDATION MÉRIEUX, 2001.
LAASER U. THE INTERNET JOURNAL OF PUBLIC HEALTH EDUCATION, (HTTP://WWW.ASPHER.ORG/D_SERVICES/IJPHE/I-JPHE_HOME_PAGE.HTM). 1999; 1.

MINISTRY OF HEALTH KAZAKHSTAN, WHO, ASPHER. KAZAKHSTAN SCHOOL OF PUBLIC HEALTH, PROJECT DOCUMENT. COPENHAGEN: REGIONAL OFFICE WORLD HEALTH ORGANISATION, 1997.

ASPHER-EUROPEAN COMMISSION. INVENTORY OF PUBLIC HEALTH AND HEALTH PROMOTION TRAINING IN THE EUROPEAN UNION, DATABASE AND BACKGROUND MATERIALS, MAASTRICHT: PRIMAVIDEO, 1997.
ASPHER. RAPID SURVEY OF NATIONAL INSTITUTES OF PUBLIC HEALTH IN THE EUROPEAN UNION. ST MAURICE: ASPHER, 1996.

LAASER U, LEEUW DE E, STOCK C. SCIENTIFIC FOUNDATIONS FOR A PUBLIC HEALTH POLICY IN EUROPE. WEINHEIM UND MÜNCHEN: JUVENTA VERLAG, 1995.

ASPHER. THE ATHENS MEMORANDUM: TRAINING AND RESEARCH IN PUBLIC HEALTH. ASPHER'S SUPPORT FOR ARTICLE 129 AND THE EUROPEAN COMMISSION'S COMMUNICATION ON THE FRAMEWORK FOR ACTION IN THE FIELD OF PUBLIC HEALTH. MAASTRICHT: UNIVERSITY OF MAASTRICHT: UNIPRINT, 1994.

KÖHLER L, BURY J, LEEUW DE E, VAUGHAN P. COLLABORATION IN EUROPEAN PUBLIC HEALTH TRAINING: POSITION PAPER ASPHER. MAASTRICHT: UNIVERSITY OF MAASTRICHT: UNIPRINT, 1994.