

Developing a Set of Pan-Canadian Health Promoter Competencies – Report of the British Columbia Consultation

Final Report

May 2015

Prepared for:

Pan-Canadian Committee on Health Promoter Competencies

ACKNOWLEDGEMENTS

This report would not have been possible without the enthusiastic input from the many health promoters in the province of British Columbia (BC) who participated in this project.

Planning of the BC online survey and workshop was supported by BC Ministry of Health staff: Cheryl Martin and Christin Petelski, with assistance from Meghan Day.

Dr. Brian Rush and Chantal Fougere, of Virgo Planning and Evaluation Consultants, prepared the online version of the pre-workshop survey, analyzed the survey results, and developed and analyzed the results from the workshop evaluation.

Dr. Brent Moloughney is the project consultant and prepared this report.

The Pan-Canadian Committee on Health Promoter Competencies gratefully acknowledges the funding support provided by the Public Health Agency of Canada.

EXECUTIVE SUMMARY

The Pan-Canadian Committee on Health Promoter Competencies is developing a set of competencies to identify the knowledge and skills for health promoters in order to:

- Inform and structure the content of health promotion training programs
- Assist in the development of competency-based job descriptions for health promoters
- Inform the development of health promotion training needs and assessment tools
- Inform curriculum development of continuing education for health promoters
- Increase understanding of the range of knowledge and skills required by health promoters to effectively plan, deliver and evaluate health promotion initiatives.

Funded by the Public Health Agency of Canada, the Committee is conducting consultations in four provinces to seek feedback on a draft set of health promoter competencies. In addition, the project will be developing and piloting a competency-based workforce development toolkit, and establishing a pan-Canadian network of health promoters. This report describes the results of the project's consultation conducted in British Columbia (BC).

Working with staff from BC Ministry of Health, a pre-workshop online survey was conducted to gather preliminary feedback on the draft competency set. The findings were then used to plan and conduct workshops to gather additional information regarding competency statements with lower levels of agreement. Information was also shared and discussed regarding a competency-based toolkit and interest in becoming part of the pan-Canadian network of health promoters.

A total of 92 responses were received to the on-line survey. The majority of respondents spent most of their time on health promotion-related activities, had been working in health promotion for more than five years, and work for a Regional Health Authority. While high levels of agreement were expressed for most of the draft competency statements, some items received lower levels of agreement and were prioritized for discussion at the workshop.

There were a total of 21 workshop participants and 35 teleconference participants that took part in the consultation. The number of participants would have been greater except a workshop and teleconference had to be cancelled due to consultant illness. The input received during the consultation will be used to inform the future revision to the competency set and glossary.

A total of 48 individuals submitted their name for inclusion in the health promoter network through the on-line survey or workshop. Overall, there were high levels of satisfaction with the workshop. Feedback encouraged increasing the opportunities for group discussion in future consultations.

Based on the findings from this consultation and its timing with respect to project completion, it is recommended to:

- 1. Incorporate feedback from this consultation in conjunction with other inputs to make a final revision to the competency set and associated glossary.
- 2. Notify network members when the revised competency set and glossary become available.
- 3. Make this report available to BC consultation participants.

TABLE OF CONTENTS

Acknowledgements	ii
Executive Summary	iii
Introduction	1
Approach	2
Results	3
Pre-Workshop Survey Results	3
Participants	3
Agreement with Competency Statements	3
Statements That Should be Removed or Added	7
Volunteers for Pan-Canadian Health Promotion Network	7
Workshop Results	7
Discussion of Themes Not Specific to Particular Competency Statements	8
Discussion of Specific Competencies	8
Toolkit	10
Use of Health Promoter Competencies in BC	10
Pan-Canadian Health Promoter Network	10
Workshop Evaluation	11
Discussion	12
Conclusion	14
Appendix 1 – Consultation Versions of the Health Promoter Competencies and Glossary	15
Health Promoter Competencies – v5 (November 2014)	
Health Promoter Competencies' Glossary – v2.1 (June 2014)	
Appendix 2 - Pre-Workshop Survey Results	
Descriptive Statistics	22
Levels of Agreement with Competency Statements	25
Appendix 3 - List of Workshop and Teleconference Participants	30
Appendix 4 - Workshop Evaluation Form	
Appendix 5 - Workshop Evaluation Results	
References	

Developing a Set of Pan-Canadian Health Promoter Competencies – Report of the BC Consultation

INTRODUCTION

The identification of the knowledge and skills (i.e., competencies) for public health practice is a fundamental building block of the *Pan-Canadian Framework for Public Health Human Resources Planning*. Following the identification of a set of public health core competencies, several disciplinary groups have been pursuing the development of discipline-specific competencies to more explicitly define the package of competencies for practice.

Starting in 2006, Health Promotion Ontario (HPO) began working to develop a set of competencies for health promoters in order to:

- Inform and structure the content of health promotion training programs
- Assist in the development of competency-based job descriptions for health promoters
- Inform the development of health promotion training needs and assessment tools
- Inform curriculum development of continuing education for health promoters
- Increase understanding of the range of knowledge and skills required by health promoters to effectively plan, deliver and evaluate health promotion initiatives.

In collaboration with the Public Health of Agency of Canada (PHAC), the following foundational documentsⁱ were developed:

- A literature review on health promoter competencies³
- An environmental scan encompassing health promotion organizations, roles, networks and trends in Canada⁴
- A discussion paper based on the above documents which included an initial draft set of discipline-specific competencies for health promoters.⁵

The initial draft set of health promoter competencies was the subject of consultations in 2007 at each of the conferences of HPO and the International Union of Health Promoters and Educators.⁶ With the interest of other provinces, a Pan-Canadian Committee on Health Promoter Competencies was established and a consultation conducted in Manitoba in 2008.⁷

ⁱ Copies of these reports may be found on the project's website: http://www.healthpromotercanada.com/foundation-documents/

In the absence of continuing project funding, the field used the existing set of competencies partially validated by the Ontario and Manitoba consultations. With recent funding from PHAC, the Pan-Canadian Committee on Health Promoter Competencies has been re-invigorated. Over the course of the project, consultations have been conducted in four provinces on the health promoter competencies with the development and piloting of a competency-based workforce development toolkit. Establishing a pan-Canadian network of health promoters is also being pursued. This report summarizes the consultation conducted in British Columbia (BC).

APPROACH

The objectives of the consultation were as follows:

- 1. To seek feedback on the draft health promoter competency set
- 2. To describe the development of a competency-based workforce development toolkit that is being piloted
- 3. To seek interest in participation in a Pan-Canadian network of health promoters.

Following the initial consultations in Manitoba and Nova Scotia, the health promoter competency set was updated and an accompanying glossary developed. In response to consultation questions regarding the relationship between the health promoter competencies and the public health core competencies, a comparison of these two competency sets was made leading to the addition of two domains prior to the final two consultations in BC and Alberta. These domains are: 'Diversity and Inclusiveness'; and, 'Leadership and Building Organizational Capacity'.

The consultation versions of the health promoter competency set and glossary are provided in Appendix 1. An online surveyⁱⁱ was used to gather information prior to the workshop to identify priority issues for discussion. BC Ministry of Health staff reached out to their contacts in the Regional Health Authorities (RHAs), Provincial Health Services Authority (PHSA), First Nations Health Authority (FNHA), universities, and non-governmental organizations in order to inform stakeholders of the consultation. Similar to other consultations, a pre-workshop online survey was utilized to identify areas of agreement and areas needed for further discussion.

The approach used in other consultations to 'piggy-back' on an existing meeting of health promoters was not an option in BC. Working with the consultation planning group, it was decided to host three smaller in-person workshops (Victoria, Vancouver and Surrey) and an additional two teleconferences to capture feedback from other parts of the province. Unfortunately, the Vancouver workshop and one of the teleconferences had to be cancelled due to consultant illness. A make-up teleconference was conducted at a later time.

-

ⁱⁱ Virgo Planning & Evaluation Consultants created the online version of the survey and prepared a descriptive summary of the results. They also summarized the results of the workshop evaluation.

iii Dates of the consultations: Victoria (Feb 25/15); Surrey (Feb 26/15); Teleconferences (Mar 3 & 25/15).

RESULTS

The results from the pre-workshop survey are presented first, which are then followed by the workshop results.

Pre-Workshop Survey Results

Participants

There were a total of 92 responses to the pre-workshop on-line survey. Overall, the majority of respondents:

- Spend 75% or more of their time on health promotion-related activities.
- Have been working in health promotion for over five years.
- Work in one of the RHAs
- Work as program staff or non-management positions.

'Health promotion' was the most frequently identified primary discipline of respondents followed by 'public health or other nurse'.

Appendix 2 provides more detailed results regarding the survey respondents.

Agreement with Competency Statements

For each draft competency statement, the survey asked for the level of agreement on a 5-point likert scale as to whether the statement:

- Should be an expected competency for all health promotion practitioners
- Reflects my role as a health promotion practitioner.

Figure 1 shows the average level of agreement ('strongly agree' or 'agree') by domain. On average, there was over 80% agreement with the statements as an expected competency for all but one of the nine domains. The program plan domain had somewhat lower average agreement compared to other domains, which was due to much lower levels of agreement with statement 3.2 (develop a program budget). The policy domain also had lower levels of agreement. Table 1 lists competency statements with lower levels of agreement, as well as those generating particular concerns.

More detailed results for individual competency statements are provided in Appendix 2.

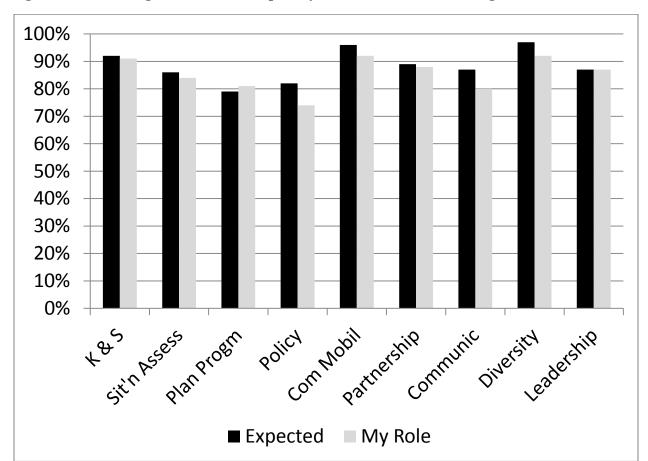


Figure 1: Extent of Agreement with Competency Statements, Domain Averages

Table 1: Summary of Competency Statements with Lowest Levels of Agreement

Competency Statement	Level of Agreement*		Representative Comments		
	Expected Competency	Reflects My Role			
1.2 Apply theory to health promotion planning, implementation, and evaluation.	90% agree 6% neutral 4% disagree	87% agree 12% neutral 1% disagree	 Apply 'theory' is vague; what type of theory? Mean health promotion theory? What about 'best practices', 'evidence-based practice', 'evidence'? 		
2.1 Conduct population assessment using existing or collected data for a specific health issue.	79% agree 14% neutral 6% disagree	78% agree 14% neutral 6% disagree	 Doesn't include 'partnering with communities' Need to be familiar with population assessment, but not expect to conduct this assessment – specialized area (seems like epidemiology) 		
3.2 Develop a program budget.	56% agree 27% neutral 16% disagree	57% agree 15% neutral 27% disagree	 Supervisor or manager role Broaden term to project/initiative & identify capacity/infrastructure requirements Address sustainability 		
4.1 Describe the health, economic, administrative, legal, social, environmental, and political implications of policy options	76% agree 14% neutral 9% disagree	68% agree 17% neutral 16% disagree	 Don't need to describe implications – need to focus on the health issues Health policy background not needed for all health promotion practitioners – only applies to health promoters working in policy and planning Management role – not health promotion direct care providers 		
7.3 Use the media, advanced technologies, and community networks to receive and communicate information	85% agree 11% neutral 4% disagree	77% agree 16% neutral 8% disagree	 Why 'advanced' technologies? 'available' Leave to those with interest/expertise in area Not everyone should be speaking to the media Done by Communications in RHA 		
9.1 Demonstrate knowledge about the history, structure, and interaction of public health, population health, and health care services at local, provincial/territorial, national, and international levels	66% agree 26% neutral 8% disagree	71% agree 20% neutral 9% disagree	 'Demonstrate'? Or is it 'knowledge of'? Not everyone needs to know history or international aspect Is 'context' better here? 		

Competency Statement	Level of Agreement*		Representative Comments
	Expected Competency	Reflects My Role	
9.5 Contribute to maintaining	80% agree	86% agree	Assumes organization is supportive of health
organizational performance	15% neutral	11% neutral	promotion
standards.	4% disagree	3% disagree	 Not specific to health promotion
			Don't know what means
			• Use 'improve' or 'continuous improvement'
			 Does not fit with true meaning of health
			promotion
			 Can't relate health promotion with
			organizational performance

^{*}Agree= 'strongly agree' + 'agree'; Percentages may not sum to 100% due to rounding.

Statements That Should be Removed or Added

A specific question was included asking if any statements should be removed. Twenty items were identified by at least one respondent for removal with the highest number of responses being 10 for statement 3.2 (program budget), 6 for statement 9.5 (performance standards) and 5 for statement 9.1 (history, structure and interaction of services).

A total of 19 suggested additions to the competency set were made – key points included:

- Leadership (initiate and lead cross-sectoral initiative...)
- Facilitation and public engagement
- Doesn't explicitly address Aboriginal peoples
- Need to understand how governments and politicians work (in order to influence policy)
- Communities and individuals are experts and hold their own answers to complex problems
- Looking at the whole system big picture
- Collective impact theory and practice
- Developmental evaluation and complexity
- Curiosity, creativity and innovation
- Health literacy
- Inter-sectoral partnerships

Volunteers for Pan-Canadian Health Promotion Network

A total of 42 survey participants submitted their contact information for inclusion in the Network.

Workshop Results

The workshop's objectives included the following:

- Discuss the draft competencies:
 - o Summarize feedback from online survey
 - o Discuss items of uncertainty/disagreement
- Describe the development of a competency-based workforce development toolkit
- Describe plan for Pan-Canadian network of health promoters.

A total of 21 individuals attended the in-person workshops in Victoria and Surrey. The cancelled Vancouver workshop would have been the largest and had the most diverse representation including non-governmental organizations. Participants registered for the Vancouver workshop were offered an opportunity to participate in a subsequent teleconference. Overall, most workshop participants were from Vancouver Island and Fraser Health Authorities and the Ministry of Health, with one participant from the University of Victoria. Appendix 3 provides a list of workshop participants. The two teleconferences had a total of 35 participants. While names of participants were not captured, the participants reflected a range of organizations

including the other RHAs (Interior Health, Vancouver Coastal and Northern); the PHSA (BCCDC, BC Cancer Agency); Simon Fraser University; and NGOs (Canadian Cancer Society; YMCA).

Discussion of Themes Not Specific to Particular Competency Statements

Several issues were raised by participants that were not specific to particular competency statements. These included:

- Desire for alternative language to 'junior' and 'senior' competency levels (e.g., 'basic', 'advanced;/level I and level II) since the existing language could be mistaken for age or seniority
- Suggest address broadness of 'health issues' in the glossary
- Role of education is not sufficiently represented; usefulness of an 'education' background; use of educational theories; and the use of education approaches (e.g., group education; 'train the trainer')
- 'Evidence' needs to be broader to consider from outside health field; community-level local data
- Perhaps place domains 8 and 9 earlier
- Social marketing more than communication/promotion.

Discussion of Specific Competencies

Item 2.1- Conduct a Population Assessment

The current wording for this competency statement is as follows:

2.1 Conduct population assessment using existing or collected data for a specific health issue.

The main challenge with this statement is that the wording 'population assessment' suggests an epidemiologist role (e.g., preparing a health status report), which is not the intent. Previous attempts to address this issue led to the inclusion of a glossary description to clarify what would be expected of a health promoter.

A health promoter retrieves and synthesizes relevant population health information to inform the development of program and policy interventions.

In retrospect, this description appears to be better in capturing the actual expectation. This was confirmed by workshop participants. Some also emphasized that this should not be limited to quantitative sources, but also include qualitative as well.

Item 3.2 – Develop a Program Budget

The current wording for this competency statement is as follows:

3.2 Develop a program budget.

This statement had the lowest level of agreement among the competency statements. In introducing the issue, it was noted that to be able to support community groups to do budgeting, that the health promoter therefore required the knowledge and skills to do so. In addition, in contrast to other practitioners, health promoters were more likely to be involved in grant applications and project management. While the potential involvement in grant applications resonated with participants, the term 'budget' was too narrow and had a 'management' feel to it. Key concepts to capture in a reworded statement included:

- Identifying and project managing broader set of resource needs (\$, people, IT, communications, etc.)
- Securing resources (e.g., project grant, business case); leveraging resources
- Return on investment; economic evaluation
- Addressing sustainability of the resources.

Domain 4 – Policy

The pre-workshop survey results raised a number of issues about the statements in this domain (see earlier Table 1). Feedback from workshop participants included:

- Challenges that work not understood or supported at times, discouraged
- Not everyone wants to work in policy (some provide direct service)
- Advocacy discouraged; role to advocate for others to advocate
- Recognize that different types of policy work; large 'P' for major government policies, but also small 'p' within organizations (e.g., decisions by a school principal affecting school foods)
- Gaps in positions and competency development lack of critical mass in RHAs
- Under legislation, MHOs have ability to publicly advocate whereas other staff do not
- Important in order for people to work across sectors (e.g., Collective Impact)
- Drive system level needs
- Create structural change in health determinants.

Item 9.1 – History, Structure and Interaction of Health Services

The current wording for this competency statement is as follows:

9.1 Demonstrate knowledge about the history, structure, and interaction of public health, population health, and health care services at local, provincial/territorial, national and international levels

This statement had the second lowest level of agreement among the competency statements. Discussion in workshops suggested a number of improvements:

- Consider 'all levels' instead of local, P/T, national and international
- Consider 'foundational knowledge' or 'public health way'
- Cultural context
- Value and contribution from public health and health promotion (? Link to 9.2)
- Influence/work within
- Systems thinking and understanding context, roles and contributions in order to work effectively/navigate within this milieu
- System navigator
- Know the history in order to influence policy
- BC is complex with a lot of players need to know 'who's who'; need to know history and structure

Toolkit

A brief overview of the competency-based toolkit was provided. Participants were urged to visit the <u>website</u> and review or use one or more of the tools.

Use of Health Promoter Competencies in BC

Key themes to the feedback on potential uses of the health promoter competencies included:

- Train and educate reference when review/update programs
- Use for orientation
- Inform position descriptions
- Outcome assessment of a position
- To work at full scope, need developmental opportunities
- Interest in pursuing 'collective impact'

Pan-Canadian Health Promoter Network

The vision for a Pan-Canadian Health Promoter Network was briefly outlined for the participants. This included the Network as a communication mechanism to provide updates to the competency set, as well as the content and piloting of the toolkit. In addition to those that volunteered for inclusion in the Network within the pre-workshop survey, a sign-up opportunity

was also provided at the workshops resulting in six additional individuals adding their contact information.

Workshop Evaluation

Participants were asked to complete an evaluation form at the end of the workshop (see Appendix 4 for form). A total of 17 (85%) workshop participants submitted a completed evaluation form. Figure 2 indicates high levels of satisfaction with the workshop. Among respondents, almost all (88% or more) of respondents were satisfied or very satisfied with the workshop duration, presentation, group discussion and overall impression of the workshop.

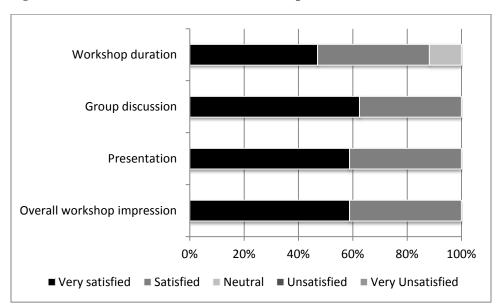


Figure 2: Levels of Satisfaction with Workshop, n=17

What Appreciated Most

Responses grouped into five main themes: reviewing feedback from the pre-workshop survey; the group discussion; the relaxed/informal consultation environment; opportunity to interact across parts of public health; and, the opportunity to provide input.

What Was One Thing of Greatest Value to Participant

Responses grouped into the following themes: open discussion/dialogue; different/inter-disciplinary perspectives; deeper understanding of the competencies; and, interest in the toolkit.

Suggestions for Improvements to Consultation

Main themes included: providing time to read over and comment on statements; broader participation with greater promotion of workshop; and, no suggested changes.

Key Messages to Take Back to Organization and/or Offer Colleagues

There were two main themes: that the competencies are being developed and need to be supported; and, to review the toolkit.

Appendix 5 provides additional details from the workshop evaluation.

DISCUSSION

The BC consultation is among the last of the scheduled provincial consultations for this project. The consultation was successful in acquiring feedback on the draft competency set, raising awareness of the toolkit, as well as seeking interest in the Pan-Canadian Health Promoter Network. Health promoters working in a variety of settings responded to the survey and attended the workshop. While levels of agreement with the draft competencies were generally high, a number of suggestions were made for their improvement.

With the current project sun-setting later this year, a final revision to the competency set and glossary is planned. This will need to consider feedback from multiple sources including: this consultation, the other consultations; the project website including the toolkit evaluation survey; and, the planned workshop at the CPHA conference. In addition, reviewing the contents of any recent health promoter competencies such as those from New Zealand should also occur.

Overall, the approach of having a pre-workshop survey followed by the in-person workshop was an efficient means of gathering information. Some unique challenges were encountered in planning the consultation including the lack of an existing network of health promoters. Considerable effort was expended by the Ministry of Health staff through a variety of contacts to gain the response that was achieved. In addition, unlike other provinces in which there was an existing event being attended by health promoters that could be piggy-backed upon, the decision was made for a series of smaller workshops. Unfortunately, consultant illness during the course of these workshops resulted in cancelling of one workshop and one teleconference. Nevertheless, the consultation achieved 92 survey responses, 21 workshop participants and 35 teleconference participants, with 48 volunteers for the health promoter network.

Based on the preceding analysis, it is recommended to:

- 1. Incorporate feedback from this consultation in conjunction with other inputs to make a final revision to the competency set and associated glossary.
- 2. Notify network members when the revised competency set and glossary become available.

3.	3. Make this report available to BC consultation participants.			

CONCLUSION

The BC consultation successfully received feedback on the draft health promoter competencies, which will be used to inform the final revisions to the competency statements and glossary. A total of forty-eight health promoters volunteered for inclusion in the Pan-Canadian Health Promoter Network.

APPENDIX 1 – CONSULTATION VERSIONS OF THE HEALTH PROMOTER COMPETENCIES AND GLOSSARY

Health Promoter Competencies – v5 (November 2014)

Health Promotion Knowledge and Skills

- 1. Demonstrate knowledge and skills necessary for health promotion practice that includes:
 - 1.1 Apply a population health promotion approach, including determinants of health and health equity, to the analysis of health issues.
 - 1.2 Apply theory to health promotion planning, implementation and evaluation.
 - 1.3 Apply health promotion principles in the context of the roles and responsibilities of population and public health settings.
 - 1.4 Describe the range of interventions available to address population and public health issues.

Situational Assessments

- 2. Partner with communities to conduct a situational assessment for a specific issue that includes:
 - 2.1 Conduct population assessment using existing or collected health data for a specific health issue.
 - 2.2 Access and critically appraise evidence (i.e. published and grey literature, systematic reviews, and promising practices) on the health issue and effective interventions.
 - 2.3 Conduct an environmental scan to identify community assets, resources, challenges and gaps.
 - 2.4 Analyze all data, evidence, and environmental scan findings to develop effective program and policy interventions.

Plan and Implement Health Promotion Programs

- 3. Plan appropriate health promotion programs that includes:
 - 3.1 Develop a plan to implement program goals, objectives, evaluation and implementation steps.
 - 3.2 Develop a program budget.
 - 3.3 Monitor and evaluate implementation of interventions.

Policy Development and Advocacy

- 4. Contribute to policy development and advocacy that reflects community needs and includes:
 - 4.1 Describe the implications of policy options (i.e., health, economic, administrative, legal, social, environmental, political and other factors, as applicable).
 - 4.2 Provide strategic policy advice on health promotion issues.
 - 4.3 Write clear and concise briefs for health promotion issues.
 - 4.4 Understand the policy making process to assist, enable and facilitate the community to contribute to policy development.

Community Mobilization and Building Community Capacity

- 5. Facilitate community mobilization and build community capacity around shared health priorities that includes:
 - 5.1 Develop relationships and engage in a dialogue with communities based on trust and mutual respect.
 - 5.2 Identify and strengthen local community capacities to take action on health issues.
 - 5.3 Advocate for and with individuals and communities to improve their health and well-being.

Partnership and Collaboration

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

Communication

- 7. Communicate effectively with community members and other professionals that includes:
 - 7.1 Provide health status, demographic, statistical, programmatic, and scientific information tailored to specific audiences (e.g., professional, community groups, general population).
 - 7.2 Apply social marketing and other communication principles to the development, implementation and evaluation of health communication strategies.
 - 7.3 Use the media, advanced technologies, and community networks to receive and communicate information.
 - 7.4 Communicate with diverse populations in a culturally-appropriate manner.

Diversity and Inclusiveness

- 8. Interact effectively with diverse individuals, groups and communities by:
 - 8.1 Recognize how the determinants of health (biological, social, cultural, economic and physical) influence the health and well-being of specific population groups.
 - 8.2 Address population diversity when planning, implementing, adapting and evaluating public health programs and policies.
 - 8.3 Apply culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and educational backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities.

Leadership and Building Organizational Capacity

9. Build capacity, improve performance and enhance the quality of the working environment including:

- 9.1 Demonstrate knowledge about the history, structure and interaction of public health, population health and health care services at local, provincial/territorial, national, and international levels.
- 9.2 Demonstrate how the work of health promotion supports the organization's vision, mission and priorities.
- 9.3 Contribute to developing key values and a shared vision in planning and implementing health promotion programs and policies in the community.
- 9.4 Demonstrate an ability to set and follow priorities, and to maximize outcomes based on available resources.
- 9.5 Contribute to maintaining organizational performance standards.
- 9.6 Utilize public health/health promotion ethics to manage self, others, information and resources.
- 9.7 Contribute to team and organizational learning in order to advance health promotion goals (e.g., mentor students and other staff; participate in research and quality assurance initiatives).
- 9.8 Pursue lifelong learning in the field of health promotion (e.g., professional development; practice development).

Health Promoter Competencies' Glossary – v2.1 (June 2014)

Advocacy

Interventions such as speaking, writing or acting in favour of a particular issue or cause, policy or group of people. In the public health field, advocacy is assumed to be in the public interest, whereas lobbying by a special interest group may or may not be in the public interest. Advocacy often aims to enhance the health of disadvantaged groups such as First Nations communities, people living in poverty or persons with HIV/AIDS.¹

A combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or programme.²

Brief (Policy)

A policy brief should present the rationale for choosing a particular policy option in a current policy debate. It requires succinct consideration of policy options for a particular audience, such as officials, politicians, journalists, advocates and researchers. As any policy debate is a market place of competing ideas, the purpose of a policy brief is to convince the target audience of the relevance or urgency of an issue and the need to adopt the proposed policy or course of action outlined, thereby serving as an impetus for change. Since health promotion policy issues tend to be relatively complex, briefs need to succinctly consider the issue and policy options for decision makers.

Critically appraise evidence

The process of carefully and systematically examining research to judge its trustworthiness, and its value and relevance in a particular context.⁶

Determinants of health

The range of personal, social, economic and environmental factors which determine the health status of individuals or populations.²

Definable entities that cause, are associated with, or induce health outcomes. Public health is fundamentally concerned with action and advocacy to address the full range of potentially modifiable determinants of health – not only those which are related to the actions of individuals, such as health behaviours and lifestyles, but also factors such as income and social status, education, employment and working conditions, access to appropriate health services, and the physical environment.

These, determinants of health, in combination, create different living conditions which impact on health.¹

Environmental Scan

The acquisition of information about events, trends and relationships in the organization's external environment to assist planning organizational action. The approach is tailored to the issue and context. Typically, a broad range of issues is examined covering social, economic, political, technological and other trends. Information is gathered from a variety of sources that may include surveys, interviews, focus groups and site visits, as well as leading-edge thinkers.⁷

Grey literature

Informally published written material (such as reports) that may be difficult to trace via conventional channels such as published journals and monographs because it is not published commercially or is not widely accessible. It may nonetheless be an important source of information for researchers, because it tends to be original and recent.⁷

Health communication

Health communication is a key strategy to inform the public about health concerns and to maintain important issues on the public agenda. The use of the mass and multi media and other technological innovations to disseminate useful health information to the public increases awareness of specific aspects of individual and collective health as well as importance of health in development.^{2,3}

Health equity

Equity means fairness. Equity in health means that peoples' needs guide the distribution of opportunities for well-being. Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices. Inequities occur as a consequence of differences in opportunity, which result, for example in unequal access to health services, nutritious food or adequate housing. In such cases, inequalities in health status arise as a consequence of inequities in opportunities in life.¹

Health issues

Health issues include, but are much broader than health conditions, and include immediate and upstream causes or contributors to health outcomes from a determinants of health perspective.

Health promotion program (and projects)

A health promotion program is generally long term and comprehensive in nature to have population health impact. It typically includes a multifaceted set of planned complementary activities characterized by multiple strategies including creating supportive environments for health, building healthy public policies, intersectoral collaboration and community involvement. In contrast, a project is typically short-term and usually a more narrowly focused activity.

Population and public health settings (roles and responsibilities of)

Public health settings include formal and informal public health organizations. Formal ones include public sector organizations at federal, provincial/territorial and local/regional levels with a public health/health promotion mandate. Informal organizations include non-governmental and academic organizations with a public health/health promotion focus. Population health settings refer to organizations whose focus or mandate is broader or different from public health such as Community Health Centres.

Population assessment

As one of the core functions of public health, assessment involves the systematic collection and analysis of data in order to provide a basis for decision-making. This may include collecting statistics on local health status, health needs, and/or other public health issues.⁸ As part of a *situational assessment*, a health promoter retrieves and synthesizes relevant population health information to inform the development of program and policy interventions.

Population health promotion

Model developed by Hamilton and Bhatti⁹ that combines consideration of Ottawa Charter action strategies, determinants of health, and various levels of action including community, sector/system, and society. Furthermore, the model is supported by evidence-based decision-making and values and assumptions.

Situational assessment

The phrase "situational assessment" is now used rather than the previous term "needs assessment." This is intentional to avoid the common pitfall of only looking at problems and difficulties, but to also consider the strengths of and opportunities for individuals and communities. It also means looking at socio-environmental conditions and broader determinants of health. A situational assessment influences planning in significant ways by examining the legal and political environment,

stakeholders, the health needs of the population, the literature and previous evaluations, as well as the overall vision for the project.⁸

Social marketing

Social marketing is the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the behaviour of target audiences in order to improve the welfare of individuals and society.³

APPENDIX 2 - PRE-WORKSHOP SURVEY RESULTS

Descriptive Statistics

Figure 3 shows that the majority of respondents spend more than half of their time on health promotion-related activities.

Figure 3: Percent of Time Spent on Health Promotion-Related Activities, (n=92)

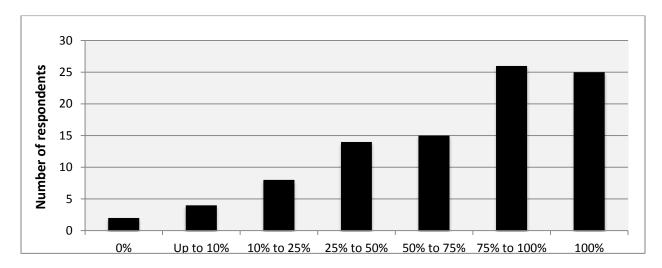


Figure 4 shows that over half of respondents have been working in health promotion for over five years.

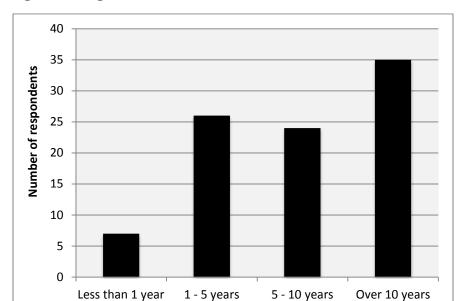


Figure 4: Length of Time Worked in Health Promotion, (n=92)

Figure 5 shows that the majority of survey respondents work for one of the RHAs.

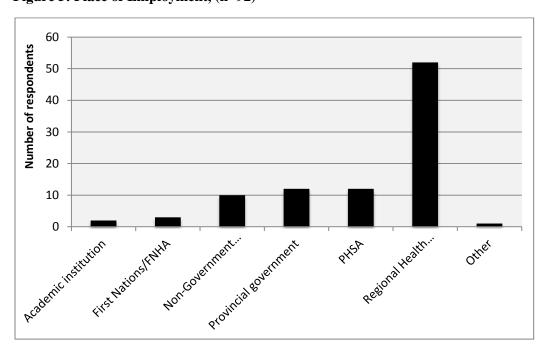


Figure 5: Place of Employment, (n=92)

Figure 6 shows that the majority of respondents self-identified as non-management program or other staff.

Figure 6: Organizational Role, (n=90)

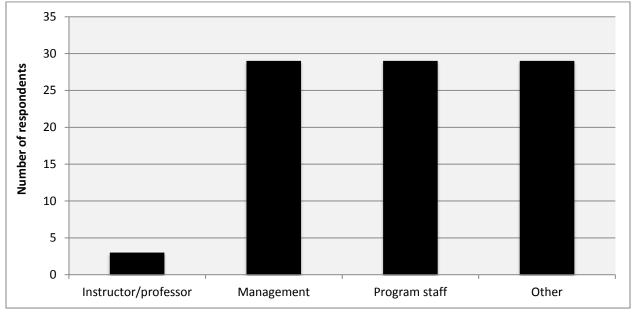
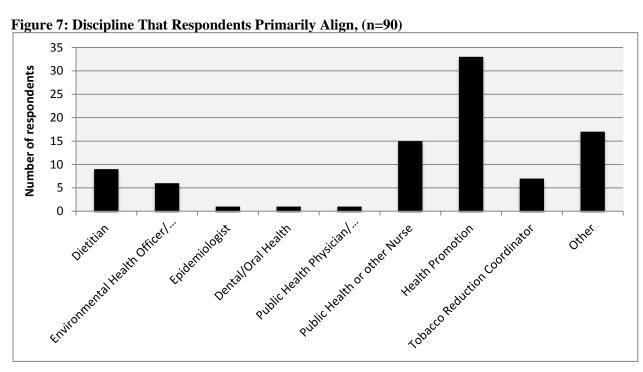


Figure 7 shows that 'health promotion' was the most commonly identified discipline, followed by 'public health or other nurse'.



Levels of Agreement with Competency Statements

The following series of Figures shows the levels of agreement for each competency statement. For each competency statement, key features include the following:

- The first bar(s) are for the 'extent of agreement with the competency' followed by bar(s) for 'extent of agreement that reflects my role'. The numeric value for 'Agree' is shown above each bar.
- Results are shown for 'Agree' and 'Don't Agree':
 - o 'Agree' = "Strongly agree' + 'Agree'
 - o 'Don't Agree' = 'Strongly disagree' + 'Disagree'
 - o Note: the results for 'Neither Agree nor Disagree' are not shown.

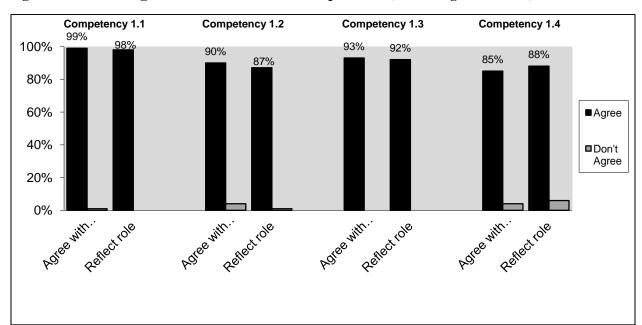


Figure 8: Levels of Agreement with Domain 1 Competencies (Knowledge and Skills)

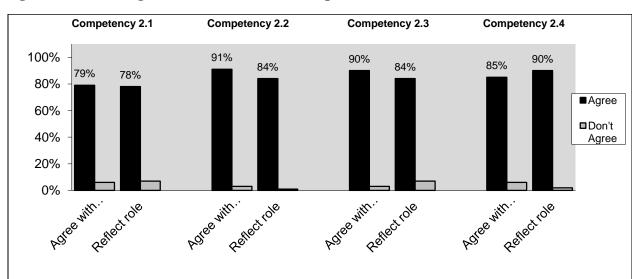
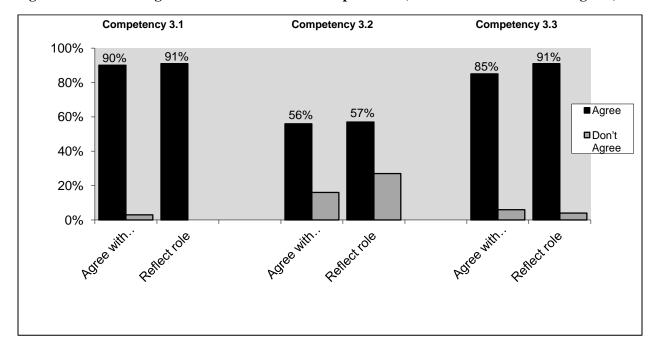


Figure 9: Levels of Agreement with Domain 2 Competencies (Conduct Situational Assessment)





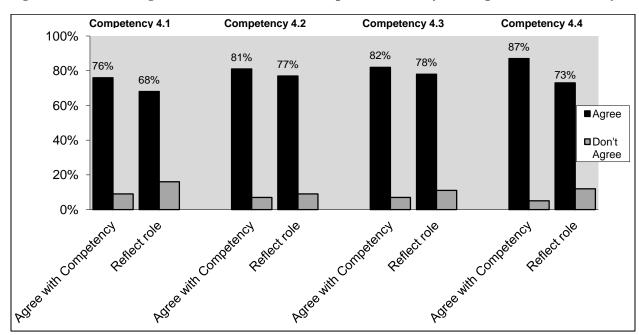
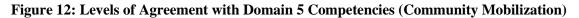
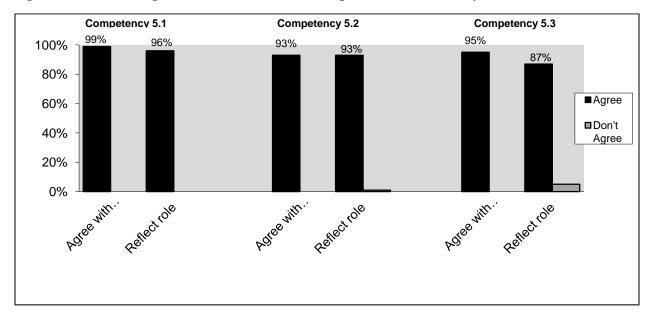


Figure 11: Levels of Agreement with Domain 4 Competencies (Policy Development and Advocacy)





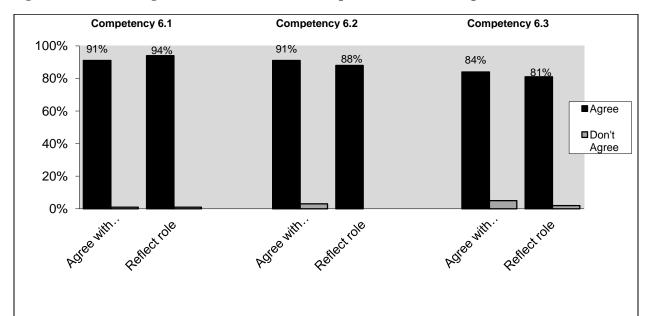
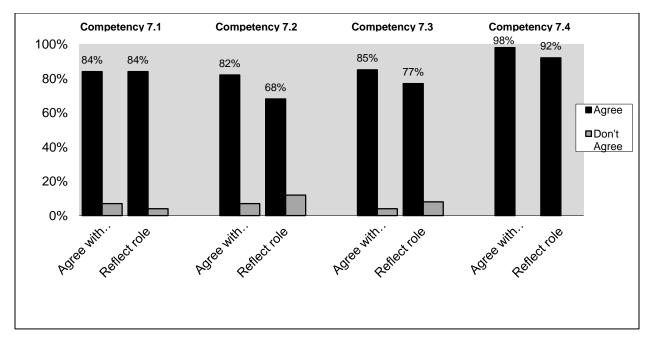


Figure 13: Levels of Agreement with Domain 6 Competencies (Partnership and Collaboration)





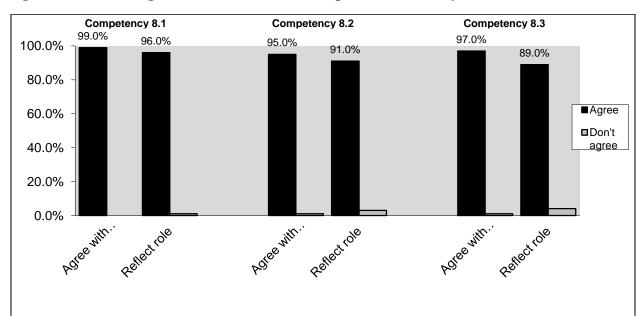
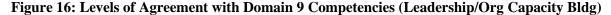
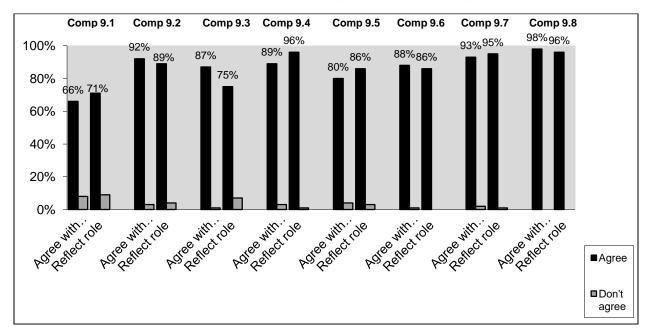


Figure 15: Levels of Agreement with Domain 8 Competencies (Diversity/Inclusiveness)





APPENDIX 3 - LIST OF WORKSHOP AND TELECONFERENCE PARTICIPANTS

The following is the list of registered participants for the workshops in Victoria and Surrey. The Vancouver workshop was cancelled due to consultant illness. An unnamed student also attended the Victoria workshop.

Name	Organization
Dee Hoyano	Vancouver Island Health Authority
Constance Haselden	Vancouver Island Health Authority
Helen Vonbuchholz	Vancouver Island Health Authority
Karen Ramsey-Cline	Ministry of Health
River Chandler	Ministry of Health
Brenda Kent	Ministry of Health
Lisa McKellar	Ministry of Health
Christin Petelski	Ministry of Health
Joan Wharf-Higgins	University of Victoria
Cheryl Martin	Ministry of Health
Anup Samra	Fraser Health Authority
Leana Baxter	Fraser Health Authority
Elaine Klassen	Fraser Health Authority
Stacey Filewich	Fraser Health Authority
Susan Legresley	Fraser Health Authority
Sandra Gill	Fraser Health Authority
Alex Kwan	Fraser Health Authority
Anne Todd	Fraser Health Authority
Ruth Hellerud-Brown	Fraser Health Authority
Tobie Patterson	Fraser Health Authority
Helena Swinkels	Fraser Health Authority

Teleconference participants included the following:*

Name	Organization
Kevin Touchet	Interior Health Authority
Pam Moore	Interior Health Authority
Cheryl Sidenberg	Interior Health Authority
Kim Howay	Interior Health Authority
Betty Brown	Interior Health Authority
Jenny Green	Interior Health Authority
Kerri Wall	Interior Health Authority
Valerie Pitman	Interior Health Authority
Brenda Marsman	Interior Health Authority
Vincent Terstappen	Interior Health Authority
Sabrian Dosanjh-Gantner	Interior Health Authority
Christine Glennie-Visser	Interior Health Authority
Chloe Curtis	Dalhousie HP Student
Reg Wulff	Northern Health Authority
Bonnie Harper	Northern Health Authority
Elle Taylor	BC Cancer Agency
Sally Erry	BC Cancer Agency
Elizabeth Sabine	YMCA
David Riddell	Vancouver Island Health Authority
Alicia Perry	BC Cancer Agency
Tanya Schilling	Northern Health Authority
Helen Yeung	Vancouver Coastal Health Authority
Kristin Ringstad	Interior Health Authority
Paola Ardiles	Simon Fraser University
Megan Oakey	Vancouver Coastal Health Authority
Anne Swann	Vancouver Coastal Health Authority
Charito Gailing	Provincial Health Services Authority
Christina Tonella	Vancouver Coastal Health Authority
Jolene Lansdowne	Vancouver Coastal Health Authority
Marianne Bloudoff	Northern Health Authority
Meghan Colenutt	BC Mental Health Services
Erin Black	Vancouver Coastal Health Authority
Sonya Lamont	BC Cancer Agency

^{*}This list may be incomplete with some additional participants not captured.

APPENDIX 4 - WORKSHOP EVALUATION FORM

Your feedback is very much appreciated in order to improve future consultation workshops. The objectives of this consultation workshop were to:

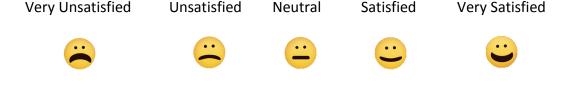
- a) Discuss the draft set of health promoter competencies
- b) Share information on competency-based workforce development toolkit
- c) Provide information on the Pan-Canadian network of health promoters.
- 1. Reflecting on these objectives, how satisfied were you with the following aspects of the consultation workshop?
- a) Duration (3 hours)

Comments:

Very Unsatisfied	Unsatisfied	Neutral	Satisfied	Very Satisfied
		<u></u>	○	Ü

b) Presentation (background, review of survey feedback, level of detail, response to questions)

c) Group discussion/feedback (clarity, level of detail, relevance)



Comments:

Comments:

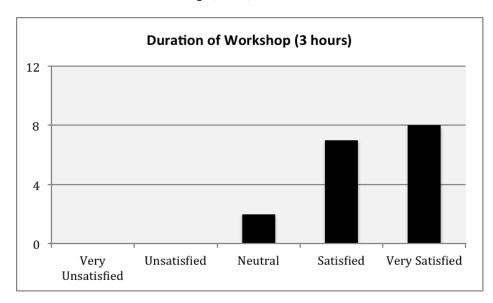
2. What did you appreciate most about the consultation workshop?

3. Other consultation workshops will be conducted as part of this project. Please offer any suggestions for improving this future event.					
4. What was your o	overall impression	on of the cons	sultation work	shop?	
Very Unsatisfied	Unsatisfied	Neutral	Satisfied	Very Satisfied	
		<u></u>			
Comments:					
5. What key messa	ges will you take	e back to you	r organization	and/or offer colleag	ues?
6. What was the on	ne thing of great	est value to y	you?		
7. Final comments					

APPENDIX 5 - WORKSHOP EVALUATION RESULTS

A total of 17 (81%) participants completed workshop evaluation forms.

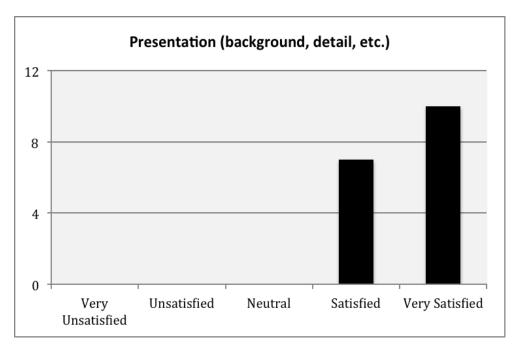
1A) – Duration of workshop (n=17)



Comments (n=2)

- Happy it was less than three hours
- Went quickly, good use of time

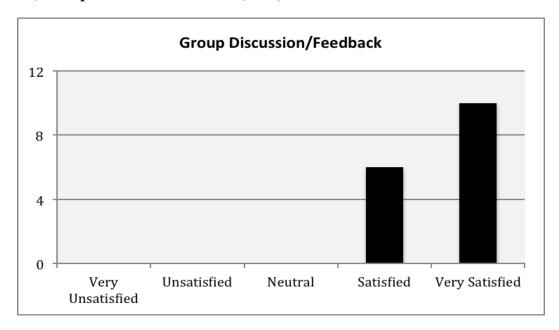
1B) – Presentation (background, detail, etc.) (n=17)



Comments (n=3)

- Very clear, organized
- Excellent, good questions to promote discussion
- Helpful

1C) Group Discussion/Feedback (n=16)



Comments (n=5)

- Group discussion was helpful to hear the perspectives on certain topics and examples
- Very helpful discussion was encouraged, we learn from others
- Lots of opportunities to chime in
- Hard to get a word in on certain topics
- Hoped there would be more people in attendance

Q2: What did you appreciate most about the consultation workshop? (n=16)

Responses for this question were broken into five main themes:

- 1. *Survey report-back:* Attendees appreciated the opportunity to review the feedback from the pre-workshop survey.
- 2. *Group discussion*: The majority of respondents enjoyed the group discussion and appreciated the interactive nature of the workshop.

- 3. *Relaxed/informal environment*: Attendees indicated that they liked the relaxed, informal feeling of the consultation, and that the environment was friendly and non-jugemental.
- 4. *Collaboration*: Attendees appreciated the opportunity to interact across sectors in the public health system (e.g., academic, government, health authority), and the contributions from various perspectives.
- 5. *Providing input*: Attendees appreciated the opportunity to provide input into the competencies and felt the workshop was a true consultation, where their input was valued and taken into consideration.

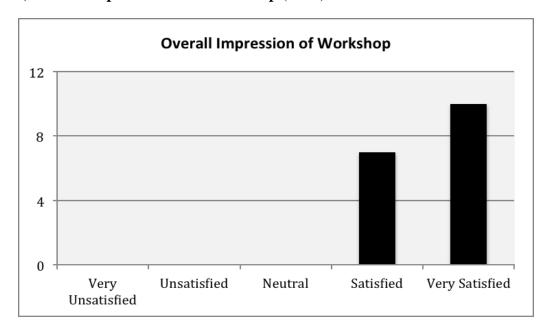
Q3 – Please offer any suggestions for improving future consultations (n=7)

Suggestions include:

- 1. Providing attendees with time to read over and comment on statements (for those who may not recall the original survey/responses)
- 2. Broader participation
- 3. Promote the workshop to public health staff more broadly

Three respondents indicated that they would keep the consultation the same (no problem to repeat as-is).

4) Overall impression of the workshop (n=17)



Comments (n=2)

- Delighted this work is happening
- Good direction on where clarity and feedback were needed

Q5 – What key messages will you take back to your organization and/or offer colleagues?

(n=15)

Two main themes:

1. Competencies:

- That they're being developed
- That they're imminent
- Need support at the local level to implement some of the competencies
- Are an important tool to define health promotion practice and secure staff that are able to do the health promotion work

2. Toolkit: Review the toolkit

Other responses:

- Survey feedback
- Feedback on lower-rated competencies

Q6 – What was one thing of greatest value to you? (n=13)

- Open discussion/dialogue: Many respondents appreciated the open discussion
- Different/interdisciplinary perspectives: Respondents indicated that feedback from a number of perspectives on various topics (and in particular, budgets) helps to recognize common issues
- *Deeper understanding of the competencies*: How competencies can be used to fit discipline-specific, and/or overall competency development; how the competencies are relevant to all health promotion professionals
- Toolkit: Several respondents have the strongest interest in the toolkit

Q7 – Final Comments (n=9)

- All respondents said thank you/that the workshop was excellent.
- One respondent indicated that they hope the input would be incorporated into the work.

REFERENCES

- (1) Joint Task Group on Public Health Human Resources. Building the public health workforce for the 21st century. A pan-Canadian framework for public health human resources planning. Ottawa: Public Health Agency of Canada, 2005.
- (2) Public Health Agency of Canada. Core competencies for public health in Canada. Release 1.0. Ottawa: PHAC, 2007.
- (3) Moloughney BW. Development of a discipline-specific competency set for health promoters findings from a review of the literature. Prepared for Health Promotion Ontario, 2006.
- (4) Hyndman B. Health promoters in Canada: an overvierw of roles, networks and trends. Prepared for Health Promotion Ontario, 2006.
- (5) Hyndman B. Towards the development of competencies for health promoters in Canada: a discussion paper. Health Promotion Ontario, 2007.
- (6) Ghassemi M. Development of Pan-Canadian discipline specific competencies for health promoters. Summary report consultation results. Toronto: Health Promotion Ontario, 2009.
- (7) Innovative Solutions. Descriptive record: discipline specific competencies workshop for health promoters. 2008.