PAN-CANADIAN NETWORK FOR HEALTH PROMOTER COMPETENCIES

Developing a Set of Pan-Canadian Health Promoter Competencies –

Report of the Nova Scotia Consultation

FINAL

May 2014

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 Nova Scotia who participated in this project.

The Nova Scotia-based planning group for the workshop was comprised of Racheal Surette, Kenda MacFadyen, Nancy Hoddinott, and Morgane Stocker*. They were instrumental in planning and executing the pre-workshop survey and the consultation workshop.

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.

*Denotes member of the Pan-Canadian Committee on Health Promoter Competencies

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 second provincial consultation, which was conducted in Nova Scotia.

Working with a group of Nova Scotia health promoters, 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 a workshop to gather additional information regarding competency statements with lower levels of agreement. Input was also sought regarding the planned competency-based toolkit and interest in becoming part of the pan-Canadian network of health promoters.

A total of 59 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 District Health Authorities (DHAs). While high levels of agreement were expressed for most of the draft competency statements, several items received lower levels of agreement and were prioritized for discussion at the workshop.

Thirty-two health promoters attended the consultation workshop. Feedback was provided regarding possible improvements for specific competency statements and the accompanying glossary. Several suggestions were made regarding the planned toolkit. A total of 35 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, it is recommended that:

1. **Options for revisions of specific competency statements and the glossary are considered prior to the next provincial consultation.**
2. **The approach taken to planning the Manitoba and Nova Scotia consultations is pursued in subsequent consultations recognizing the need to tailor to local circumstances, as required. In addition, to build in greater flexibility into the planning of the workshop to allow for potential variation in pace.**
3. **The final version of this report and the revised version of the competency set and glossary are distributed to Network volunteers. This dissemination should be preceded by dissemination of these materials to the Nova Scotia consultation planning leads.**

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Developing a Set of Pan-Canadian Health Promoter Competencies – Report of the Nova Scotia Consultation (draft)

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*.[1] Following the identification of a set of core competencies,[2] 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 documents[i] were developed:

- A literature review on health promoter competencies[3]
- An environmental scan encompassing health promotion organizations, roles, networks and trends in Canada[4]
- 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/competencies-development/

In the absence of continuing project funding, the field used the existing set of competencies partially validated by 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 will be 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 envisioned. This report summarizes the consultation conducted in Nova Scotia, which is this project's second of four planned provincial consultations.

APPROACH

The objectives of the consultation were as follows:

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

Following the first consultation in Manitoba, the health promoter competency set was updated and an accompanying glossary developed. The consultation versions of both documents are provided in Appendix 1. An online survey[ii] was used to gather information prior to the workshop to identify priority issues for discussion. Working with health promotion contacts in Nova Scotia, the consultation was planned including:

- Scheduling the workshop so that it occurred the evening preceding the start of a conference attended by health promoters from across the province
- Promoting the online survey with the relevant target audiences in Nova Scotia
- Conduct of a 3-hour workshop (April 29, 2014)
- Development of a draft version of this report to seek comments from the Nova Scotia planning group and the Pan-Canadian Committee.

[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.

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 59 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 for District Health Authorities (DHAs)
- Work as program staff
- Identified 'health promotion' as their discipline.

Appendix 2 provides more detailed results regarding the survey respondents.

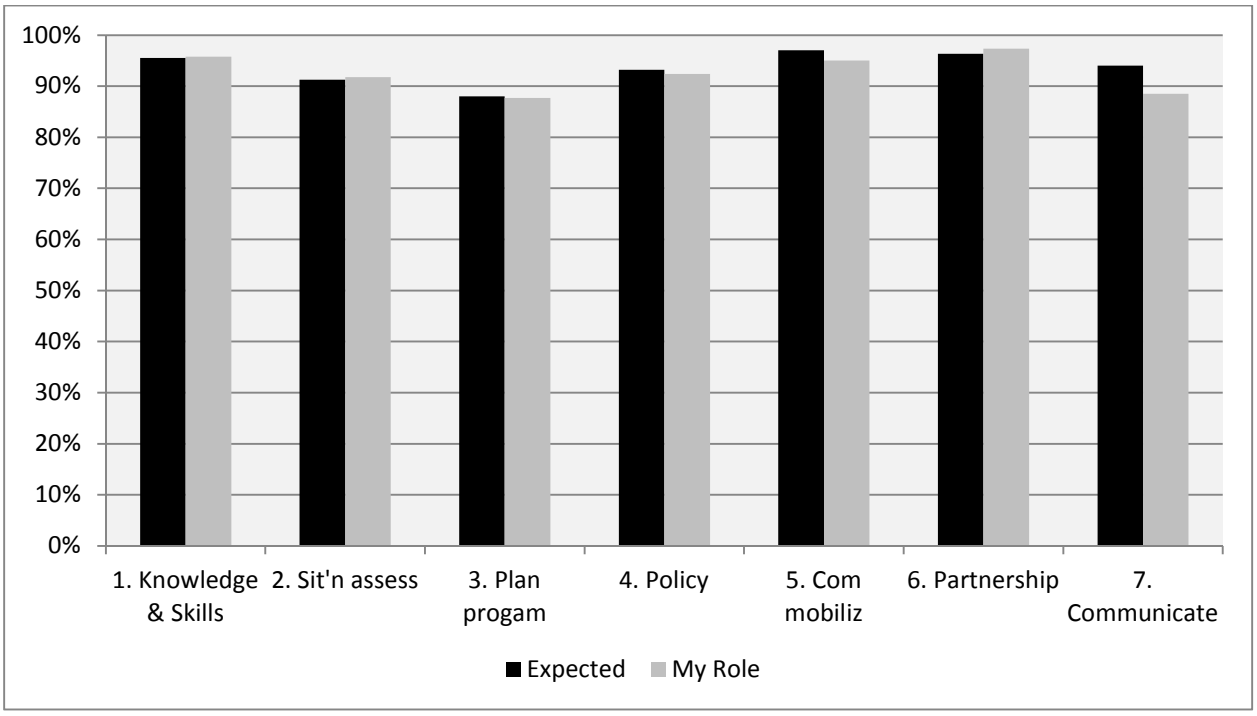
Agreement with Competency Statements

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 85% agreement with the competencies for the seven domains. Results for individual competency statements are provided in Appendix 2.

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



The program plan domain had somewhat lower average agreement, which was due to much lower levels of agreement with statement 3.2 (develop a program budget). Several other statements had somewhat higher levels of neutrality or disagreement. Table 1 lists these competency statements, their levels of agreement, and the main themes of written comments from the online survey.

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

Competency Statement	Level of Agreement*		Representative Comments
	Expected Competency	Reflects My Role	
2.1 Conduct population assessment using existing or collected data for a specific health issue.	87% agree 7% neutral 6% disagree	87% agree 9% neutral 4% disagree	• Unsure on this as I would see this as being lead more with the epidemiologist and health intelligence team but working together in collaboration on certain issues. • Progress can be stymied by the need to provide unavailable data before proceeding. • Not all health promotion practitioners are knowledgeable in data collection and where to find such data.
3.1 Develop a plan to implement program goals, objectives, evaluation and implementation steps.	96% agree 0% neutral 4% disagree	92% agree 0% neutral 8% disagree	• This competency statement may be limited by the reference to "programs"...suggest instead using the term "initiatives" • I don't agree with the use of the term "programs". In my role, I work on health promotion initiatives but would not consider myself a programmer. The world "program" is well-established in people's minds as only relating to delivering programs to individuals.
3.2 Develop a program budget.	74% agree 18% neutral 8% disagree	77% agree 12% neutral 12% disagree	• This has never been asked of me • Remove 'program' and replace with 'initiative' • There is no 'budget' for our work other than salary and benefits. • Suggest: 'contribute to development of a program or project budget'

Competency Statement	Level of Agreement*		Representative Comments
	Expected Competency	Reflects My Role	
3.3 Monitor and evaluate implementation of interventions.	94% agree 6% neutral 0% disagree	94% agree 4% neutral 2% disagree	• Again for me there is a need to clarify system roles. The time-consuming nature of research and evaluation may be better planned at the provincial level of the PH system. It can be implemented at the local level but local level resources used to conduct thorough evaluation is arguably not the best use of very limited HP resources.
4.3 Write clear and concise briefs for health promotion issues	86% agree 10% neutral 4% disagree	84% agree 8% neutral 8% disagree	• Writing concise briefing notes is a very minor part of what needs to occur in terms of development around policy change and the role of health promoters. • There are different roles on a team. As long as someone on the team has competency to do this - I'm not sure if everyone has to have the same level of competency in this area
5.3 Advocate for and with individuals and communities to improve their health and well-being	95% agree 6% neutral 0% disagree	89% agree 10% neutral 2% disagree	• Take it away from development of policy for the individual, to develop for the community, changing the environment, culture, norms etc • I'm a little nervous about misinterpretation of what advocacy with individuals could be construed as. As a population health promoter, I think of the community, not individuals, as my "client."

Competency Statement	Level of Agreement*		Representative Comments
	Expected Competency	Reflects My Role	
7.2 Apply social marketing and other communication principles to the development, implementation and evaluation of health communication strategies.	88% agree 6% neutral 6% disagree	84% agree 10% neutral 6% disagree	• More commonly implement social media tools as opposed to social marketing techniques. • Strongly disagree with the notion of pairing social marketing and "communications" as a single competency. Social marketing is about utilizing comprehensive proven behaviour change tactics and strategies (policy, supportive environment, skill building, etc.), and sometimes may include communications as one of several elements.
7.3 Use the media, advanced technologies, and community networks to receive and communicate information.	92% agree 4% neutral 4% disagree	86% agree 8% neutral 6% disagree	• A barrier can be internal policies such as a block in the DHA's on the use of some social media. Makes some collaborative efforts difficult • I believe that this is dependent upon role. It may be inappropriate for some to participate in these activities if the primary purpose is advocacy and is public facing. If however, the intention is to share information and best practices among networks, it is more essential.

*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. The highest number of responses was two (of 59), occurred for two statements, and reiterated previously identified issues (see Table 1).

A total of 13 suggested additions to the competency set were made. Key concepts included:

- Inclusion of leadership skills and practices
- Personal qualities such as being adaptable, innovative and motivated
- Sex and gender analysis
- Health promotion ethics
- Relationship-building and community development approach competencies
- Some comments related to strengthening existing competencies (e.g., health equity focus; advocacy).

Advice Regarding the Planned Toolkit

Key themes included:

- Clear/plain language with real world examples; advice how to integrate new resource with existing resources, job analysis, collective agreements and practices.
- Involve human resources
- Have additional tools – e.g., workplan planning, coaching, skills testing
- Pilot in variety of settings
- Recognize different levels of proficiency – e.g., experienced vs. entry level
- How workplaces can advance and value role of health promoter.

Volunteers for Pan-Canadian Health Promotion Network

A total of 34 survey participants submitted their contact information for inclusion in the Network.

Implications for Conducting the Workshop

In reviewing the survey's results, several implications were identified for conducting the workshop:

1. Need to emphasize that the competencies address health promotion practice from a population perspective.
2. Need to view any one competency statement in the context of the rest of the statements within its domain, and the competency set overall.
3. The competency set requires supporting material. This likely includes:
    a. An introduction and context (e.g., population focus, Ottawa Charter)
    b. Glossary to provide definitions.
4. Need to address the proficiency issue. One approach would be to have different levels of position descriptions in the toolkit.
5. Need to discuss and seek greater feedback on competency statements with lower levels of agreement.

Workshop Results

The workshop's objectives included the following:

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

A copy of the workshop's agenda is provided in Appendix 3.

A total of 32 individuals attended the evening 3-hour workshop, which preceded a planned health promotion-related conference that was starting the next day. Most of the participants were from DHAs or the provincial government, although there were also participants from non-governmental settings and Dalhousie University. Appendix 4 provides a list of workshop participants.

Discussion of Specific Competencies

Item 2.1- Conduct a Population Assessment

The current wording for the domain stem and this competency statement is as follows:

> *2:* Partner with communities **to conduct a situational assessment for a specific issue** that includes:
>
> > 2.1 Conduct population assessment using existing or collected data for a specific health issue.

The plenary presentation described that this statement was not indicating health promoters to function as an epidemiologist, but to be able to pull together relevant data to define the problem from a health perspective as part of the overall situational assessment. Discussion indicated that:

- The glossary definition for 'population assessment' should be reviewed.
- The verb 'conduct' should be re-considered.

Item 3.1 – Develop a Program Plan

The current wording for the domain stem and this competency statement is as follows:

> ***3: Plan appropriate health promotion programs*** *that includes:*
>
> > 3.1 Develop a plan to implement program goals, objectives, evaluation and implementation steps.

The plenary presentation described that many survey respondents viewed the word 'program' to be limited to services provided to individuals. This perspective was confirmed by many of the workshop attendees. While this may be an issue within Nova Scotia, it is not widely shared elsewhere. For example, Quebec, Ontario and British Columbia utilize the word 'program' to describe the comprehensive population-based approaches that public health applies. Since the competency set is Pan-Canadian in scope, it is not possible to remove the word 'program' from the competency set. To address this issue, it was discussed that:

- A definition for 'program' would be added to the glossary indicating the comprehensiveness of its meaning.
- Recognizing that use of the competency set is voluntary and adaptable, that its application in Nova Scotia could be tailored to the local context (i.e., use alternative wording instead of 'program' when apply the competencies in position descriptions, etc.).

There were additional issues identified in a conversation with the project consultant during a break at the workshop that conducting formal or in-depth evaluations of programs is beyond the scope of core expectations for health promoters. The same issue was implied by a survey respondent.

Item 3.2 – Develop a Budget
The current wording for the domain stem and this competency statement is as follows:

> ***3: Plan appropriate health promotion programs*** *that includes:*
>
> 3.2 Develop a program budget.

Most of the survey respondents' issues related to the lack of current involvement in budgeting or the lack of a budget for non-human resources. In the plenary presentation, it was noted that the competencies are not just about what is, but also looking to the future. Furthermore, that the human resource rating of positions often looks to budgetary input/control. A participant noted that accessing grant money is a mechanism for acquiring resources, which requires being able to develop a budget. For this competency statement, it was discussed that there is:

- Potential to reword to 'develop and manage' a 'program or project' budget.

Item 4.3 – Writing a Brief
The current wording for the domain stem and this competency statement is as follows:

> ***4: Contribute to policy development and advocacy*** *that reflects community needs and includes:*
>
> 4.3 Write clear and concise briefs for health promotion issues.

Many of the survey respondents' issues related to the relative importance of writing a brief. In the plenary presentation, it was noted that the strategic direction in Nova Scotia is to focus more upstream on policy and that a policy brief is a common tool to pursue policy change. Furthermore, that this involves a skill that is different from providing policy advice. For this competency statement, it was discussed that:

- The level of expected proficiency should be reflected in the toolkit's sample position descriptions.

Item 5.3 – Advocating for Individuals
The current wording for the domain stem and this competency statement is as follows:

> ***5:*** **Facilitate community mobilization and build community capacity around shared health priorities** that includes:
>
> > 5.3 Advocate for and with individuals and communities to improve their health and well-being.

The predominant issue with this competency statement is the use of the word 'individuals', which may be interpreted to indicate individual-level interventions. It was indicated in the plenary that this was not what was intended and that 'individuals' may have been used instead of 'groups'. For this competency statement, it was discussed that:

- The evolution of this competency statement would be reviewed to determine the origin of 'individuals' and to consider revising the statement's wording.

Item 7.2 – Apply Social Marketing and Other Communication Principles
The current wording for the domain stem and this competency statement is as follows:

> ***7:*** **Communicate effectively with community members and other professionals** that includes:
>
> > 7.2 Apply social marketing and other communication principles to the development, implementation and evaluation of health communication strategies.

Some survey respondents had raised conceptual issues regarding this statement. Since it was unclear how best to address these issues, workshop participants were asked to discuss this statement in small groups. Overall, all of the groups agreed that there should be a competency statement for health communication strategies and made suggestions on how to improve upon the existing statement.

Conceptual suggestions for improving this competency statement included:

- What to do with 'social marketing':
  - Keep it included as a fundamental piece
  - Concern with singling it out – recommend omit it
  - Make it a separate bullet on its own
- Simplify the statements – may need to increase number of bullets with expanded clarity
- Define the key terms: 'social marketing', 'health communication strategies', 'communications', 'communication principles' and 'advanced technologies'.

Suggested rewording of the statement included:

- Apply social marketing and other communication principles to the development, implementation and evaluation of health ~~communication~~ promotion strategies.
- Apply ~~social marketing and other~~ communication principles to the development, implementation and evaluation of health ~~communication~~ promotion strategies.
- Apply social marketing and other communication principles to the development, implementation and evaluation of health ~~communication~~ promotion strategies, as appropriate.
- Understand and apply media, resources and social marketing techniques ~~and other communication principles~~ to the development, implementation and evaluation of health communication strategies.
- ~~Apply social marketing and other~~ Incorporate communications ~~principles to the development, implementation and evaluation of~~ into health ~~communication~~ promotion strategies.

Other comments included:

- Adding 'decision makers' to the stem of domain 7
- Include basic competency for 'understanding and practice of communication' in domain 1.

Item 7.3 – Using Media and Other Channels to Communicate
The current wording for the domain stem and this competency statement is as follows:

> ***7:*** **Communicate effectively with community members and other professionals** that includes:
>
> > 7.3 Use the media, advanced technologies, and community networks to receive and communicate information.

The predominant issue expressed by survey respondents regarding this statement was the limits to which DHA staff could utilize existing technologies such as social media to communicate with others. In responding to item 7.2, some small groups also provided comments regarding this statement:

- Use 'current' media, advanced technologies…
- Replace with 'Use current technology effectively…'

Toolkit and Implementation Issues

What Advice/Requests Do You Provide Regarding the Planned Toolkit?
Several suggestions were made including:

- Quantify what significant experience means
- Provide samples of products described in statements (e.g., briefing note; situational assessment; health promotion plan with budget)
- For each competency statement give an example for entry level vs. advanced (consider same levels as public health core competencies)
- Broad enough that content is applicable beyond public health (e.g., mental health, addiction services, etc.)
- Communication and implementation plan – especially HR departments and managers to create understanding of role of health promoter, skills required, etc.
- Overlay core competencies with health promoter competencies
- Clear framing of purpose of toolkit and examples of how can be used
- Add self-evaluation
- Case study/video describing domains (real people, real stories)
- Standardized job description samples
- Interview guide
- Behaviour-based indicators/statements for use in interview guides
- Bank of values-based questions and answers for interviews
- Orientation to health promotion for those conducting performance management/supervising others (e.g., values, approaches, difference between health education and health promotion)
- Expectations for use: competencies apply to teams or individuals? Expect to demonstrate all or some of the statements?

What Opportunities Can You Identify Conducive to Implementation of the Competencies in Your Organization?
Several suggestions were provided including:

- Link the health promoter competencies to performance appraisal tools
- Link the health promoter competencies to Nova Scotia Standards and Protocols
- Opportunity to standardize position descriptions across Nova Scotia (single health authority) – currently working on standardized descriptions for other types of positions (e.g., public health nurse)
- Protecting health promotion titled positions to work within the scope of health promotion best practice
- Link the competencies to professional development opportunities, identify gaps and engage academic to close gaps (e.g., resources linked to domains)
- Build awareness and appreciation of the role

What are the Implementation Challenges and How Can They Be Overcome?
Table 2 summarizes the identified challenges and suggested solutions.

Table 2: Implementation Challenges and Suggested Solutions

Challenge	How to Overcome (suggested solutions)
Political tide is not health promotion focussed	• Not for this project to address
Don't have a professional association to be registered with – a significant gap for employment opportunities and recognition of the work	• Incorporate this into the process. Link to competencies.
Lack of understanding of health promotion discipline	• Need an advocacy strategy for tool kit targeted to decision makers, health promoters and other health professionals
Lack of presence of health promotion at CPHA	• Re-create health promotion division
In some organizations, health promoters report to coordinators and then managers	• Flatten organization to allow health promoters to use their competencies

A number of additional challenges were identified without the identification of potential solutions:

- Consistency across province – what health promotion means. What health promoters do and practicing evidence-based health promotion.
- Classification of health promotion role – hiring process has to be competency-based
- Integrating with other disciplines
- Management and leadership understanding and encouraging/allowing competent health promoters to do their job, using their skills
- Valuing and understanding health promoters as a discipline
- Accountability – being able to explain, measure, define how using skills makes a difference.
- Defining the scope of the use of the competencies and by whom
- Promoting the value of the tool if its only for 1% of employees
- Longstanding 'educators' may be hard pressed to abide.

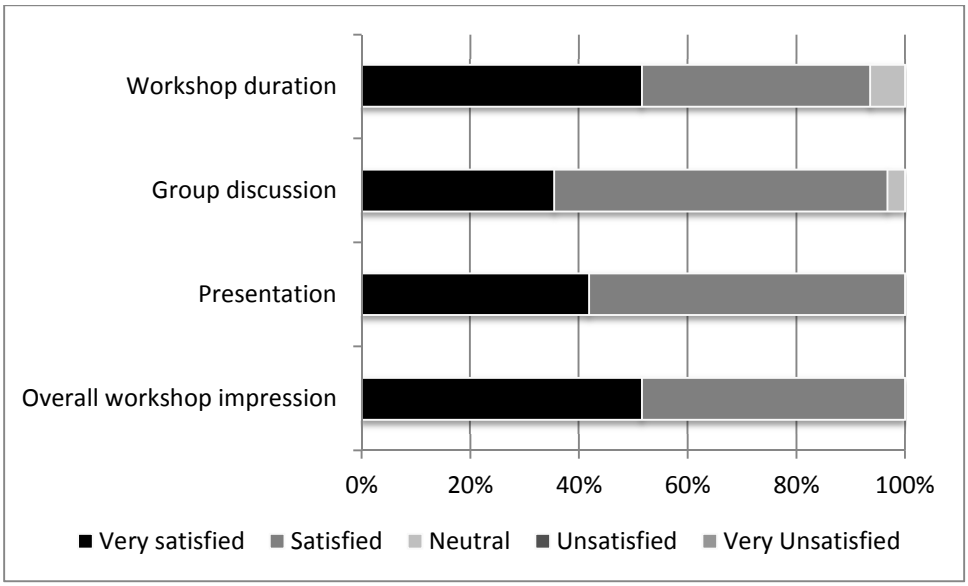
Pan-Canadian Health Promoter Network

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 workshop resulting in an additional individual adding their contact information.

Workshop Evaluation

Participants were asked to complete an evaluation form at the end of the workshop (see Appendix 5 for form). A total of 31 (97%) workshop participants submitted a completed evaluation form. Figure 2 indicates high levels of satisfaction with the workshop. Almost all (96% or more) of respondents were satisfied or very satisfied with the presentation, group discussion and overall impression of the workshop. Slightly fewer (93.5%) were satisfied with the workshop's duration.

Figure 2: Levels of Satisfaction with Workshop, n=31



Appendix 6 summarizes the workshop results.

What Appreciated Most

Of the 29 responses to this question, there were five major themes.

1. *Group discussions*: Many respondents indicated that they enjoyed the discussion portion of the workshop – respondents highlighted the small groups and ability to talk with colleagues and peers working in the health promotion field.

2. *Diverse group*: Several respondents indicated that they appreciated the representation of people from different disciplines/institutions, and that the diverse group provided an opportunity to hear from different perspectives.

3. *Opportunity to contribute:* Several respondents indicated that they appreciated having the opportunity to provide 'input', 'feedback', 'suggestions', 'to discuss and influence the health promotion competency statements' and 'being able to provide our own two cents' in the workshop.

4. *Networking:* Respondents indicated that they liked being able to network, connect with, and hear about the experiences of colleagues from other parts of the province.

5. *Content*: Several respondents appreciated discussing health promotion positions, working on the individual competencies, and hearing about survey results.

Respondents also enjoyed the *content of the workshop,* including being provided with the context/background; reviewing next steps; and clarifying any content-related issues.

Suggestions for Improving Future Consultations

A total of 17 responses were received to this question. Key themes included:

Introductions: Three respondents indicated that they would have liked time for introductions

Health promotion and public health: Two respondents indicated that many health promoters do not work in public health, and that health promotion work is done in programs beyond public health.

Attendees: One respondent suggested having more leaders/decision-makers present, and another wanted to ensure that a diverse group is present

Timing: Two respondents suggested holding the workshop during the day, rather than at night, and one respondent indicated that because the group time acts as a break, there is no need for a formal break.

Key Messages That Will Take Back to Organization and/or Colleagues
Of the 23 responses to this question, the two main themes were:

1. *Competencies and toolkit are currently under development*, and that the toolkit/reference documents will be 'useful', 'will assist in how the competencies are used', and 'will be helpful for hiring'. A respondent also indicated that the competencies are 'looking good'.

2. *Job descriptions/hiring*, specifically:

- Developing job descriptions
- Job performance appraisals
- Roles
- Hiring/recruitment of competent new practitioners
- Planning/workforce development.

As noted earlier, additional details for the workshop evaluation are provided in Appendix 6.

DISCUSSION

The Nova Scotia consultation is the second of four planned consultations to be conducted in this project. The consultation was successful in acquiring feedback on the draft competency set and the planned toolkit, as well as seeking interest in the Pan-Canadian Health Promoter Network. Overall, the level of agreement with the competency statements was the highest to-date, which may reflect the incremental improvements in the competency set and the more recent addition of a glossary. Nevertheless, the feedback suggests a number of potential competency statements that might be improved, as well as additional glossary items.

It is therefore recommended that:

1. **Options for revisions of specific competency statements and the glossary are considered prior to the next provincial consultation.**

With two completed consultations, reflections on their similarities and differences are possible:

- Having a local planning group was essential for both workshops
- In general, the sequencing of a pre-workshop survey followed by a workshop is useful
- Despite the same approach, the level of response to the pre-workshop survey differed considerably between the two provinces with a majority of those contacted in Manitoba responding and only a minority in Nova Scotia. The Nova Scotia planning group was unsure why a relatively low response occurred, but did suggest a couple of possibilities: a lack of incentives; and, recipients not recognizing the relevance since few staff have positions called 'health promotion'.

- An evening workshop appears to be more challenging for participants than an afternoon workshop. However, since the intent is to piggy-back onto an existing meeting, there is limited scheduling flexibility.
- While the workshop duration was a significant issue following the Manitoba workshop, there was extra time remaining in the Nova Scotia workshop. It is possible that the Manitoba experience led to an over-compensation in the schedule and conduct of the Nova Scotia workshop.

It is therefore recommended that:

2. **The approach taken to planning the Manitoba and Nova Scotia consultations is pursued in subsequent consultations recognizing the need to tailor to local circumstances, as required. In addition, to build in greater flexibility into the planning of the workshop to allow for potential variation in pace.**

A total of 35 health promoters from Nova Scotia volunteered to be participants in the Network. Their participation should be reinforced as the project proceeds.

It is therefore recommended that:

3. **The final version of this report and the revised version of the competency set are distributed to Network volunteers. This dissemination should be preceded by dissemination of these materials to the Nova Scotia planning leads.**

CONCLUSION

The Nova Scotia consultation successfully received feedback on the draft health promoter competencies, which will be used to improve the competency statements and glossary for the future provincial consultations. In addition, useful input was received regarding the development and piloting of the toolkit. Thirty-five 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 – v4.1 (January 2014)

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.

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.

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.

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.
4.5 Adapt policies and programs to reflect the diversity in population characteristics.

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.

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.

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.

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.[5] 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]

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 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.

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

Population health assessment entails understanding the health of populations and the factors that underlie health and health risks. This is frequently manifested through community health profiles and health status reports that inform priority setting and program planning, delivery and evaluation. Assessment includes consideration of physical, biological, behavioural, social, cultural, economic and other factors that affect health. The health of the population or a specified subset of the population can be measured by health status indicators such as life expectancy and hospital admission rates. (A public health system core function.)[1]

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]

Population health promotion

Model developed by Hamilton and Bhatti[9] 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]

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=59)

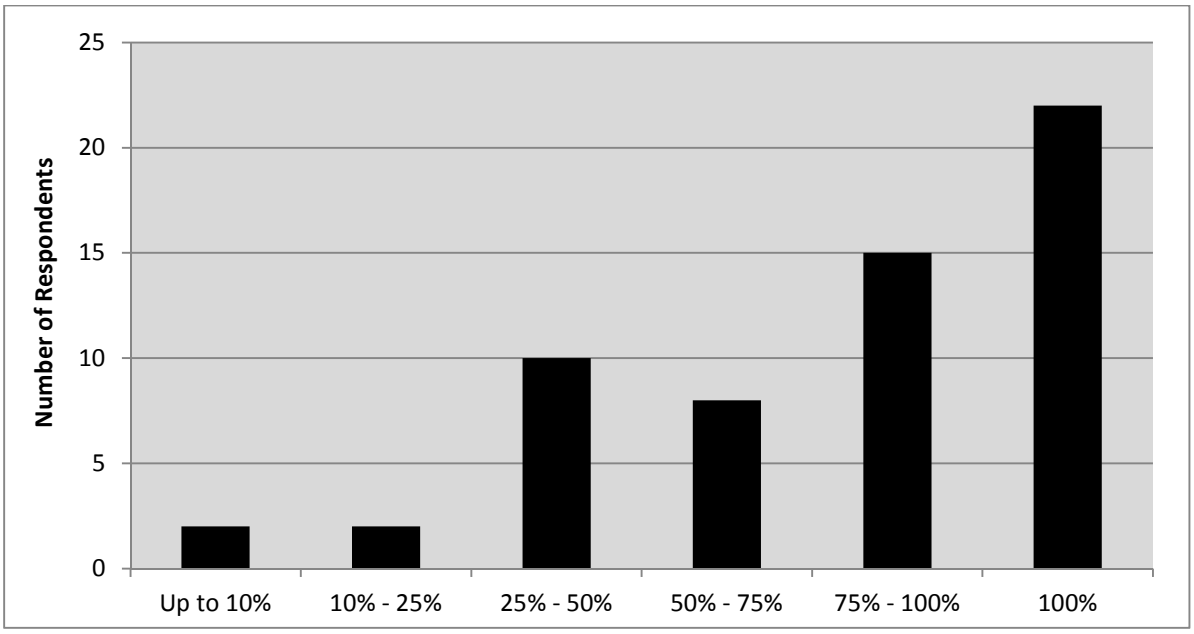


Figure 4 shows that over half of respondents have been working in health promotion for over five years.

Figure 4: Length of Time Worked in Health Promotion, (n=59)

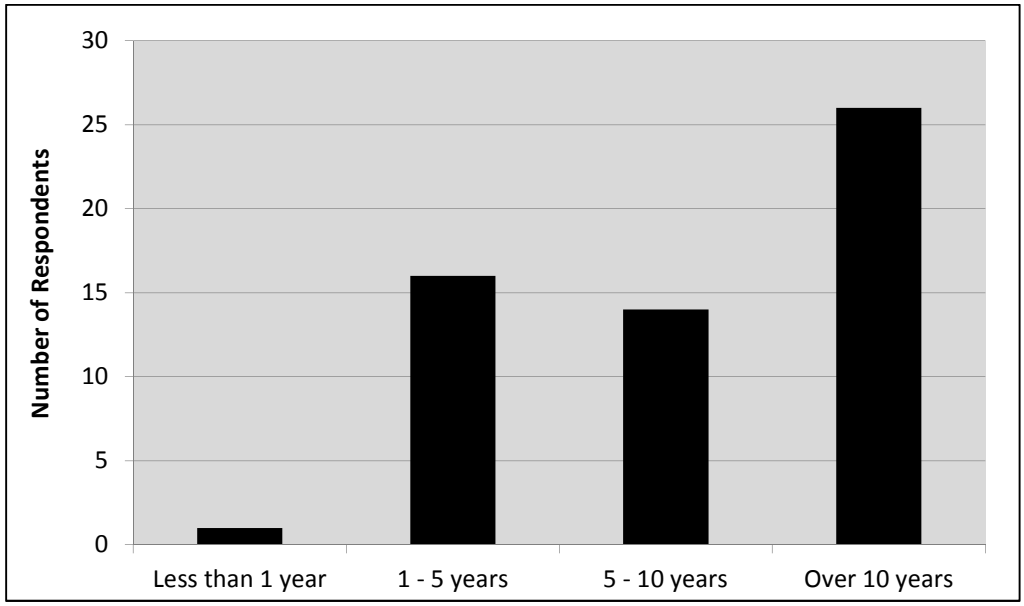


Figure 5 shows that the majority of survey respondents work in District Health Authorities.

Figure 5: Place of Employment, (n=59)

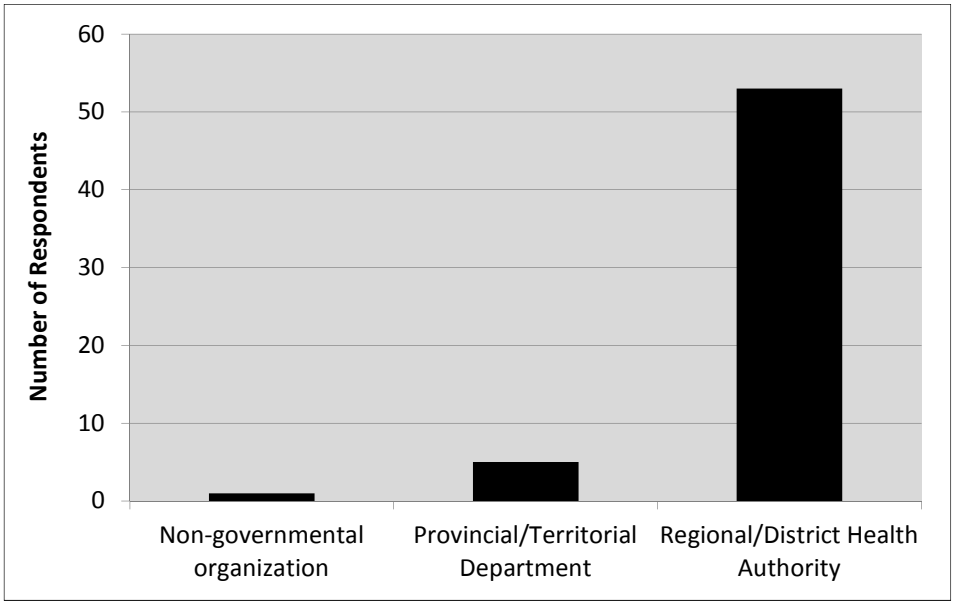


Figure 6 shows that the majority of respondents self-identified as program staff.

Figure 6: Organizational Role, (n=59)

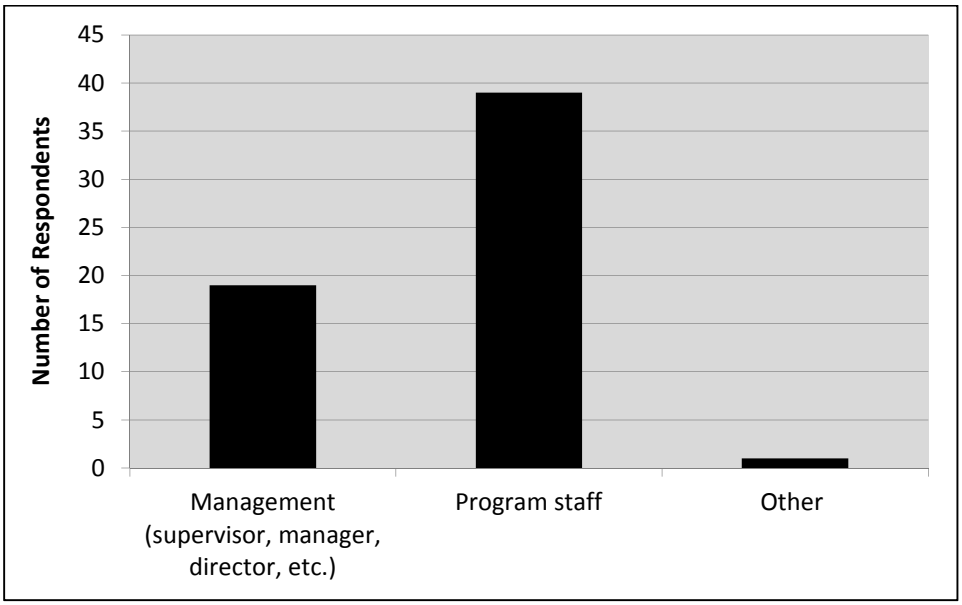
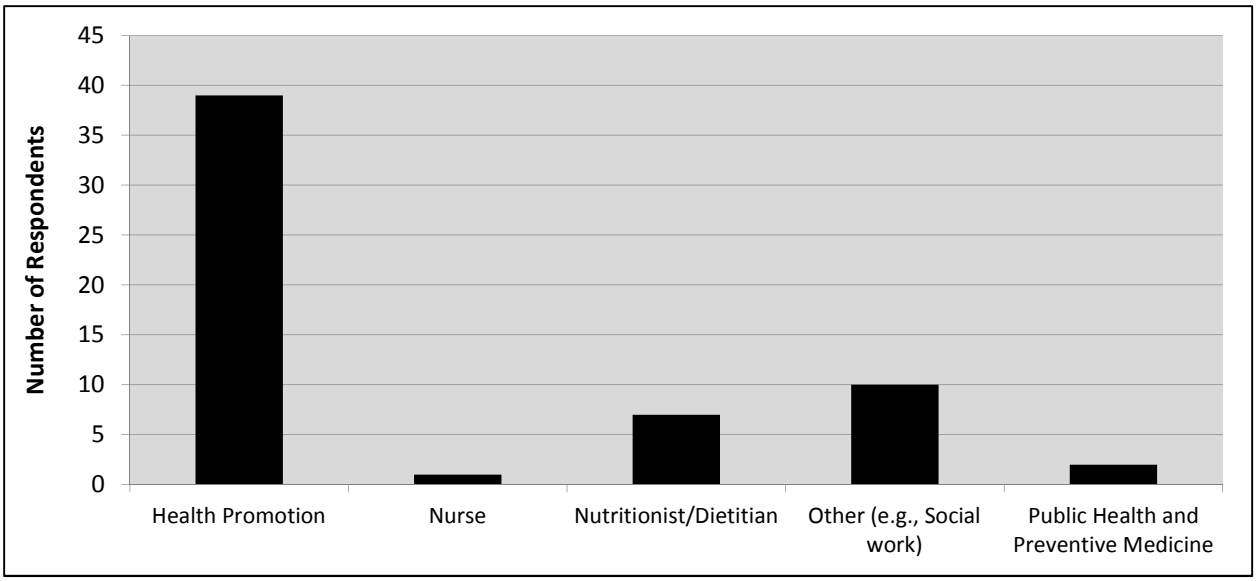


Figure 7 shows that most respondents identified their discipline as 'health promotion'.

Figure 7: Discipline That Respondents Primarily Align, (n=59)



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':
    - 'Agree' = "Strongly agree' + 'Agree'
    - 'Don't Agree' = 'Strongly disagree' + 'Disagree'
    - Note: the results for 'Neither Agree nor Disagree' are not shown.

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

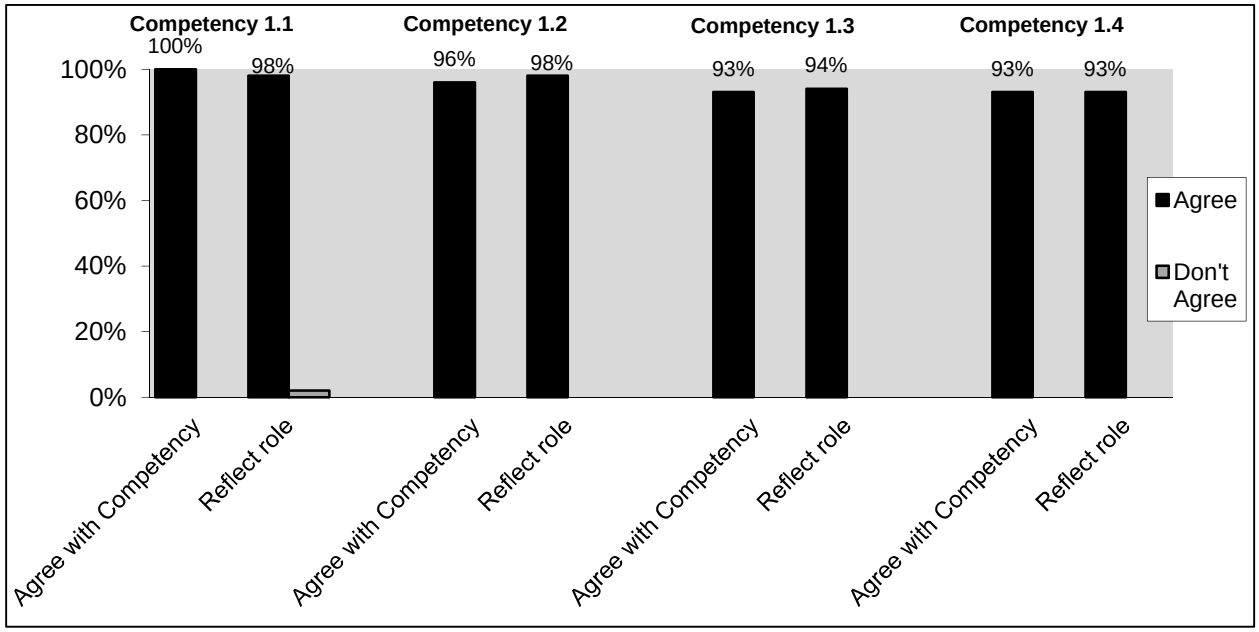


Figure 9: Levels of Agreement with Domain 2 Competencies (Conduct Situational Assessment)

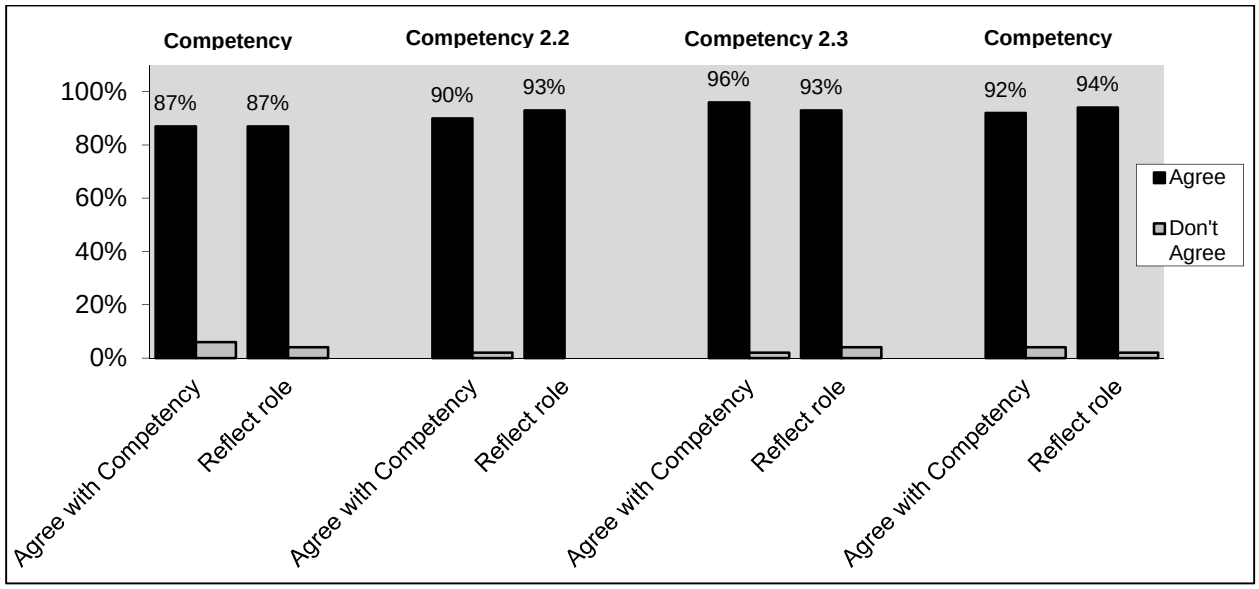


Figure 10: Levels of Agreement with Domain 3 Competencies (Plan Health Promotion Program)

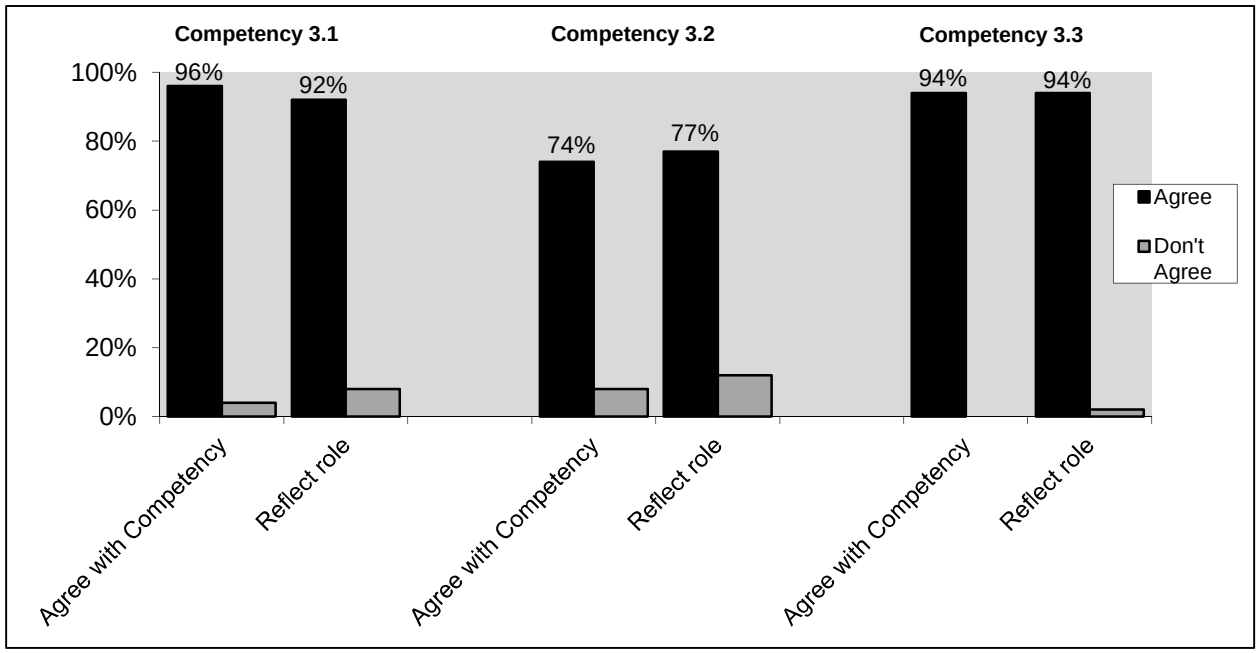


Figure 11: Levels of Agreement with Domain 4 Competencies (Policy Development and Advocacy)

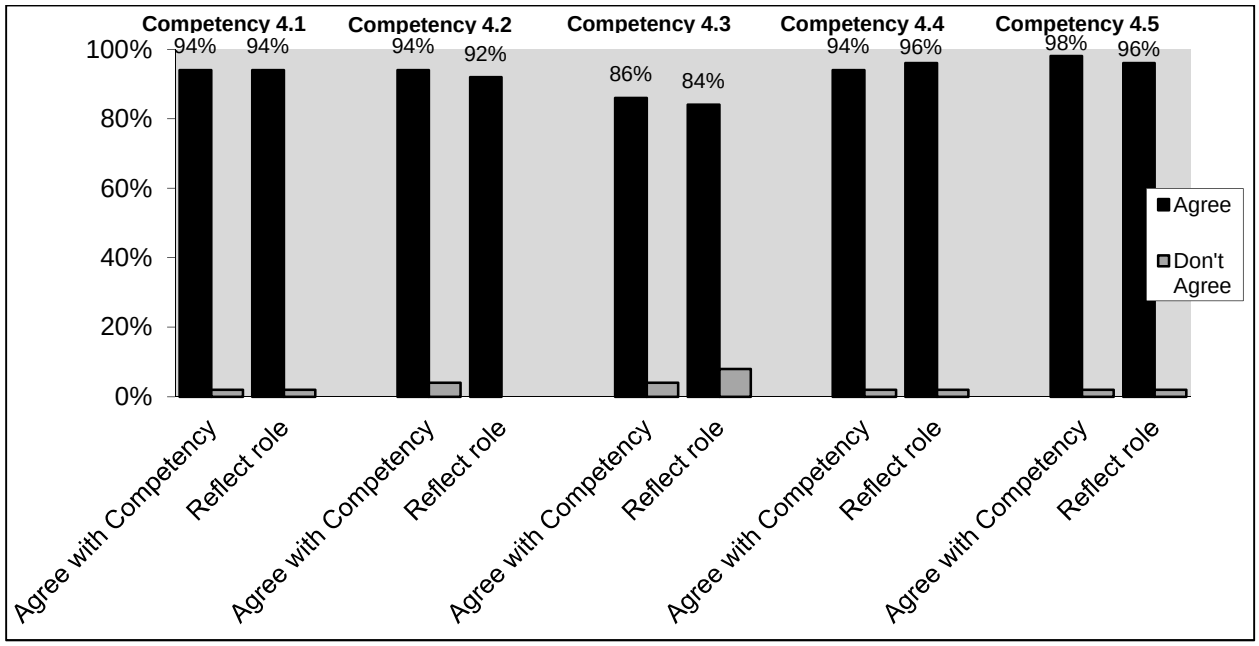


Figure 12: Levels of Agreement with Domain 5 Competencies (Community Mobilization)

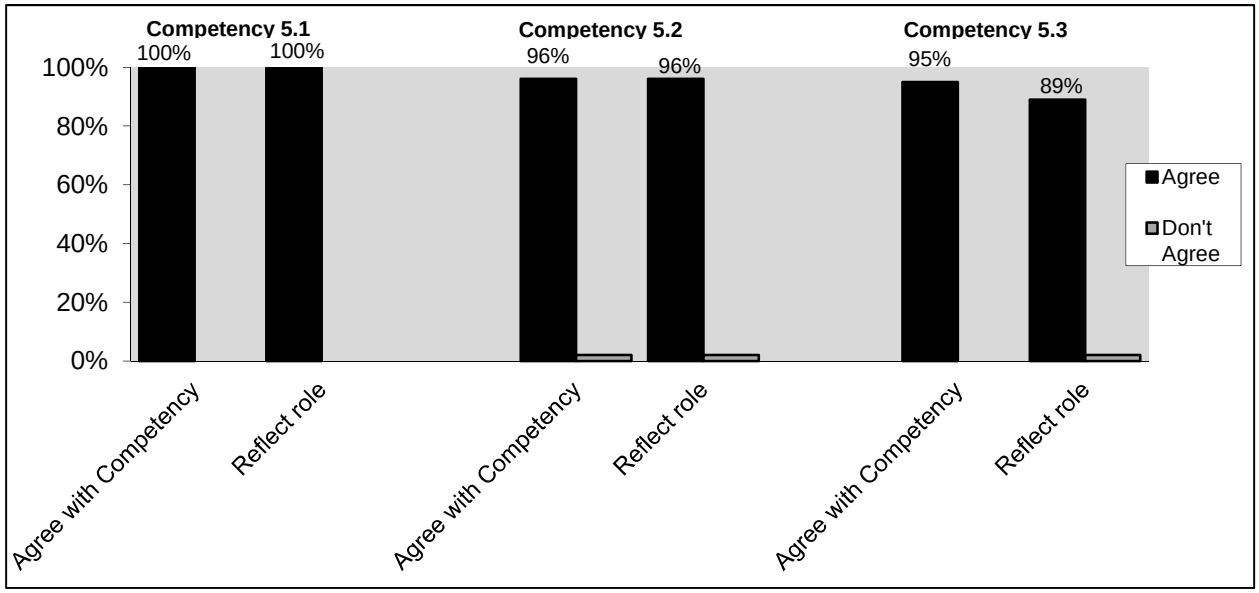


Figure 13: Levels of Agreement with Domain 6 Competencies (Partnership and Collaboration)

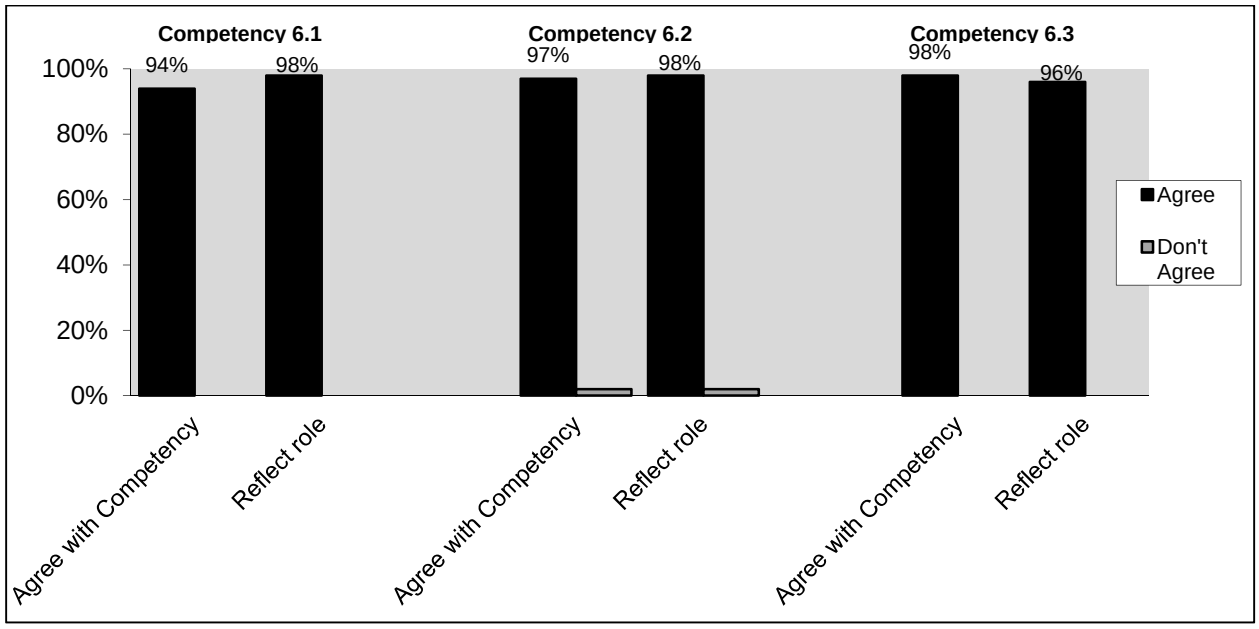
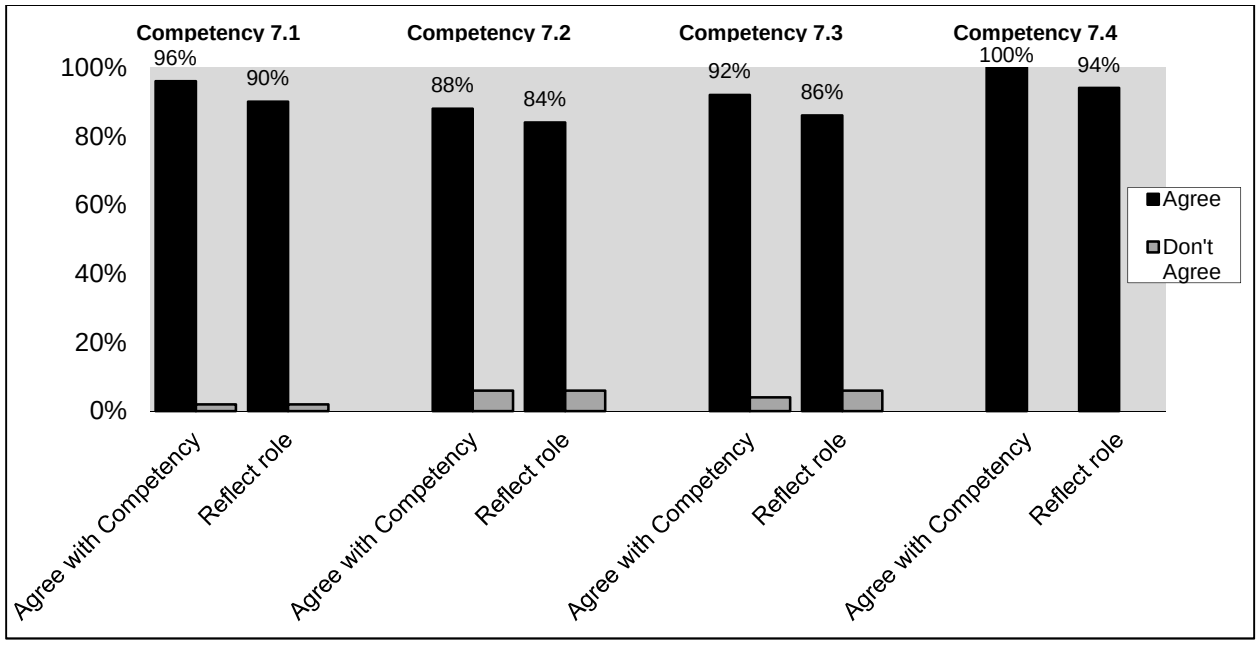


Figure 14: Levels of Agreement with Domain 7 Competencies (Communicating)



APPENDIX 3 - WORKSHOP AGENDA

Pan-Canadian Health Promotion Competencies
Nova Scotia Workshop
Tuesday, April 29, 2014
6:00 – 9:00 p.m.

Agenda

Time	Item
6:00-7:30	Welcome & Introductions Project Overview Survey Results Discussion of Specific Competencies
7:30-7:45	Break
7:45-8:50	Discussion of Specific Competencies (cont'd) Development & Application of Toolkit Next Steps & Building Network of Health Promoters
8:50-9:00	Session Evaluation

APPENDIX 4 - LIST OF WORKSHOP PARTICIPANTS

Name	Organization
Annick Arseneau	Colchester East Hants Health Authority
Aron Ashton	Cape Breton District Health Authority
Lesley Barnes	Dalhousie University
Sheila Bird	South West Health (DHA)
Meghan Bragg	Guysborough Antigonish Strait Health Authority
Beth Currie	Cape Breton District Health Authority
Gwenyth Dwyn	Annapolis Valley Health Authority
Holly Gillis	Capital Health (DHA)
Jennifer Heatley	Atlantic Collaborative on Injury Prevention
Catherine Hebb	Annapolis Valley Health Authority
Sam Hodder	Cape Breton District Health Authority
Nancy Hoddinott	IWK Health Centre
Jenna Hopson	South Shore Health (DHA)
Kate Johnston	IWK Health Centre
Brenda Leenders	Colchester East Hants Health Authority
Kenda MacFadyen	Department of Health and Wellness
Steve Machat	Department of Health and Wellness
Sharon MacIntosh	Capital Health (DHA)
Carol Mackinnon	Annapolis Valley Health Authority
Jayme MacLellan	Cumberland Health Authority
Jean MacQueen	Cape Breton District Health Authority

Name	Organization
Krista McMullin	Colchester East Hants Health Authority
Jenna McQueen	Cape Breton District Health Authority
Sophie Melanson	Cumberland Health Authority
Elizabeth Michael	Nova Scotia Association for Sexual Health
Shelley Moran	South Shore Health (DHA)
Leah Poirier	Colchester East Hants Health Authority
Phyllis Price	South Shore Health (DHA)
Trudy Reid	Cumberland Health Authority
Nancy Skinner	Pictou County Health Authority
Morgane Stocker	Capital Health (DHA)
Racheal Surette	South West Health (DHA)

APPENDIX 5 - 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 promotion competencies
b) Seek advice on development of a competency-based workforce development toolkit
c) Describe the plan for a 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)

Very Unsatisfied Unsatisfied Neutral Satisfied Very Satisfied

Comments:

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

Very Unsatisfied Unsatisfied Neutral Satisfied Very Satisfied

Comments:

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

Very Unsatisfied Unsatisfied Neutral Satisfied Very Satisfied

Comments:

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

3. Three more consultation workshops are planned in different parts of Canada. Please offer any suggestions for improving these future events.

4. What was your overall impression of the consultation workshop?

Very Unsatisfied Unsatisfied Neutral Satisfied Very Satisfied

Comments:

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

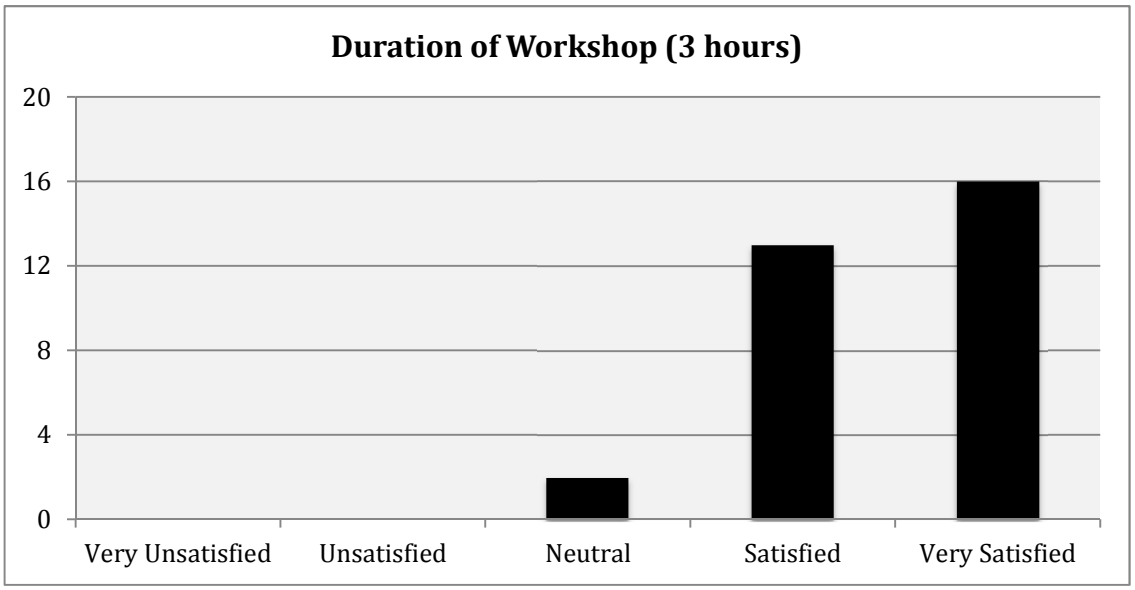
6. What was the one thing of greatest value to you?

7. Final comments

APPENDIX 6 - WORKSHOP EVALUATION RESULTS

A total of 31 (97%) completed workshop evaluation forms were received.

1A) – Duration of workshop

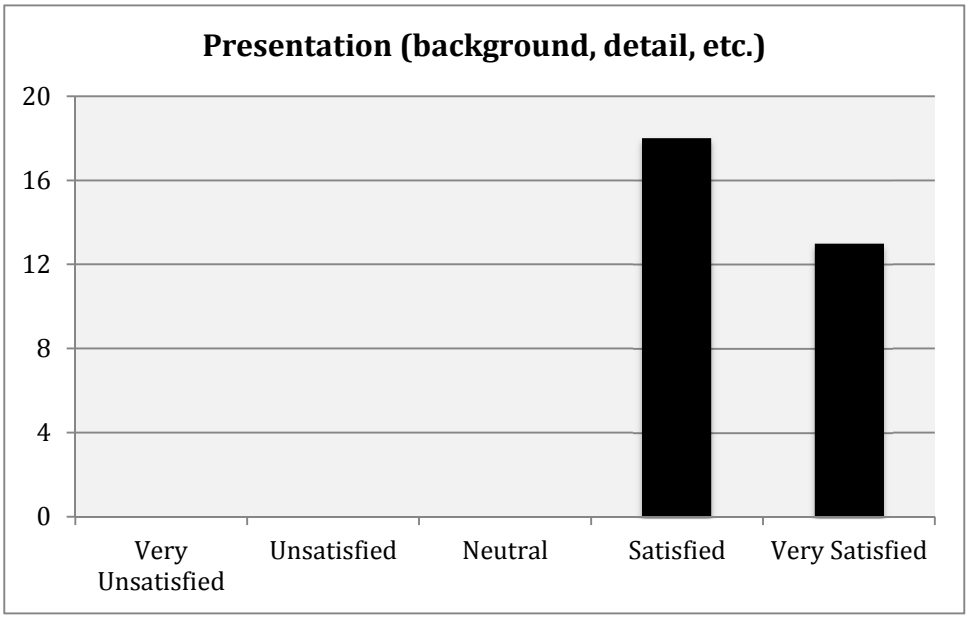


Comments:
All comments were positive – respondents indicated that the time was sufficient, the pace was good, stayed on schedule, and that the workshop was well facilitated.

Two respondents provided suggestions:

- The workshop went for 2.5 hours, but there would have been enough interesting discussion for three hours
- The time of the workshop in the evening was ‘a bit tough’

1B) – Presentation (background, detail, etc)

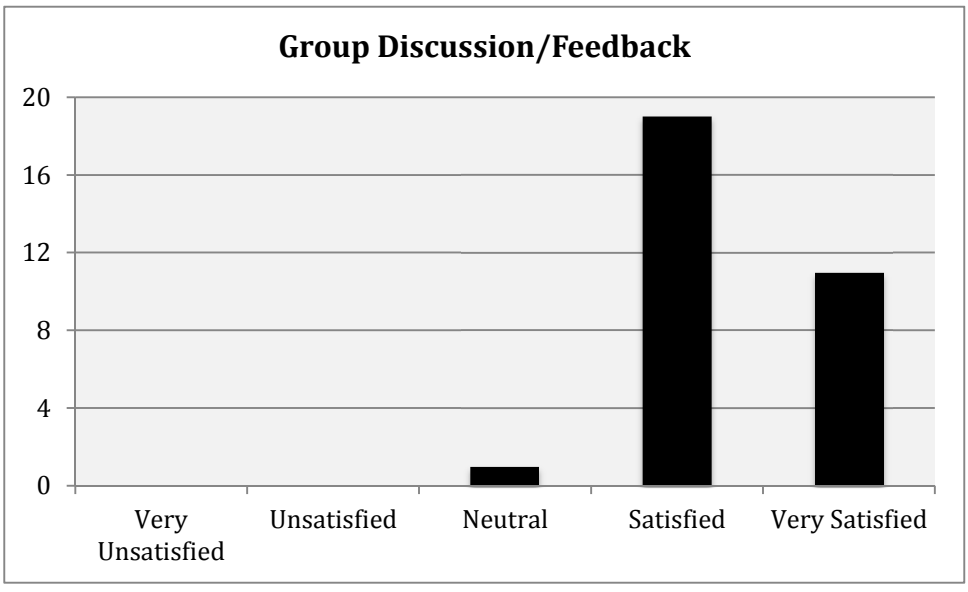


Comments:

Comments indicated that respondents were satisfied with the presentation (background, context) provided, and that the workshop was well facilitated.

One respondent indicated that if there were pan-Canadian committee members in the room, it would have been good for them to speak to the group

1C) Group Discussion/Feedback



Comments:

Feedback was fairly positive; respondents indicated that they appreciated having clear parameters around topics to ensure that the conversations were focused; that the sheets were easy to use; and that they enjoyed the diversity of disciplines in the room (made for engaging conversations).

Several suggestions were offered, including:

- Some discussion of survey results and consensus on decisions went too quickly – not really an opportunity to respond
- Would have liked to comment on some of the areas not raised by responses to the survey
- The lateness of the session was a bit tough.

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

N=29

Five main themes:

1. *Group discussions*: Many respondents indicated that they enjoyed the discussion portion of the workshop – respondents highlighted the small groups and ability to talk with colleagues and peers working in the health promotion field.

2. *Diverse group*: Several respondents indicated that they appreciated the representation of people from different disciplines/institutions, and that the diverse group provided an opportunity to hear from different perspectives.

3. *Opportunity to contribute:* Several respondents indicated that they appreciated having the opportunity to provide 'input', 'feedback', 'suggestions', 'to discuss and influence the health promotion competency statements' and 'being able to provide our own two cents' in the workshop.

4. *Networking:* Respondents indicated that they liked being able to network, connect with, and hear about the experiences of colleagues from other parts of the province.

5.*Content*: Several respondents appreciated discussing health promotion positions, working on the individual competencies, and hearing about survey results.

- Respondents also enjoyed the *content of the workshop,* including being provided with the context/background; reviewing next steps; and clarifying any content-related issues.

Q3: Please offer any suggestions for improving future consultations

N=17

Introductions: Three respondents indicated that they would have liked time for introductions

Health promotion and public health: Two respondents indicated that many health promoters do not work in public health, and that health promotion work is done in programs beyond public health.

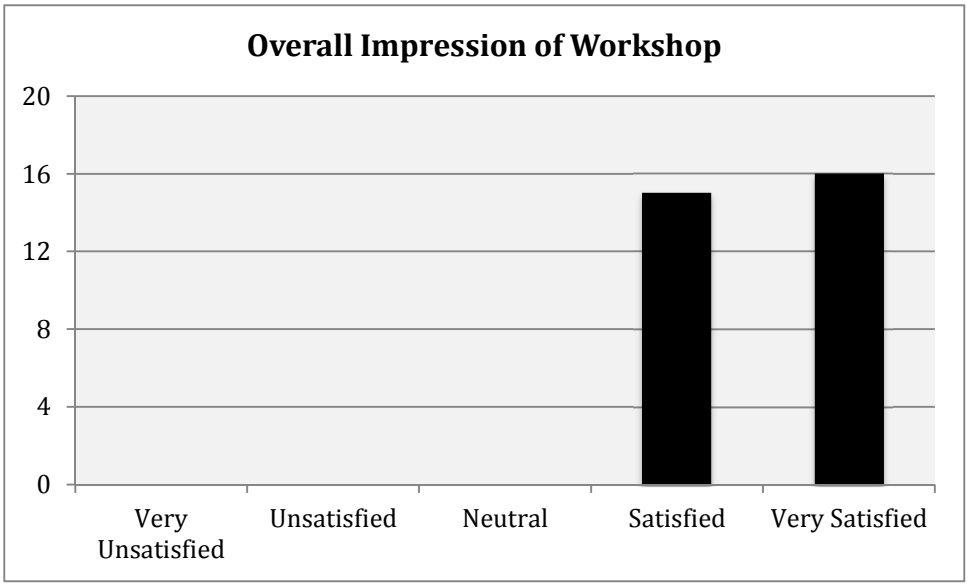
Attendees: One respondent suggested having more leaders/decision-makers present, and another wanted to ensure that a diverse group is present

Timing: Two respondents suggested holding the workshop during the day, rather than at night, and one respondent indicated that because the group time acts as a break, there is no need for a formal break.

Several other suggestions:

- Text in slides was sometimes too small for people to read from the back of the room
- One respondent indicate they would like to see some of the questions in advance
- More group discussion (less individual reflection) and no need for the pink or blue papers
- More interaction/moving around/working with new tables and people
- Opportunity to raise key issues outside of the presented items
- Time for more formal small group report back, to ensure all tables are heard to help stimulate new ideas

4) Overall impression of the workshop



Comments:

Overall, positive, respondents were happy to have attended, and appreciated participating in the survey before event to focus the discussion at the workshop.

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

N=23

Two main themes:

1. *Competencies and toolkit are currently under development*, and that the toolkit/reference documents will be 'useful', 'will assist in how the competencies are used', and 'will be helpful for hiring'. A respondent also indicated that the competencies are 'looking good'.

2. *Job descriptions/hiring*, specifically:

- Developing job descriptions
- Job performance appraisals
- Roles
- Hiring/recruitment of competent new practitioners
- Planning/workforce development

Other themes:

- Three respondents noted that the work helps to highlight the value and importance of the health promotion role, and to 'validate [my] work'
- Two respondents will use the competencies with their health promotion teams/in the workplace
- Two respondents wanted to share everything – history of the initiative, points of interest from the survey, discussion of the toolkit, describing the competencies.

Q6 – What was one thing of greatest value to you?

N=23

Three main themes:

1. The *group discussions* were of great value – many respondents appreciated having the chance to discuss with peers and colleagues. Respondents felt that the discussion helped 'deepen understanding' and enjoyed the 'good ideas generated' and the 'sharing of thoughts and ideas'.

2. Many respondents also enjoyed *networking* with others in the health promotion community, and to participate in more informal conversations with their peers.

3. A number of respondents also appreciated participating in the competency/toolkit development process:

- Several respondents appreciated having an increased understanding of the process of competency development
- Participating in the process made them feel valued
- The toolkit will be of value to [my] organization

Q7 – Final Comments

N = 12

Most respondents thanked Brent – felt the day was organized and presented very well. Workshop evaluation survey feedback indicated that Brent facilitated very well.

Two respondents noted that they would like updates or the final results of the workshops.

One respondent indicated that a note-taker should have captured the exchanges in between 'conversations'

One respondent suggested using less paper ('questions on slide and group sheet to document is enough')

One respondent suggested to 'look to existing systems and infrastructures to integrate and help them (HPCC) come alive – accreditation has great weight at local level'.

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(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.

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(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.