Health Promoters in Canada:
An Overview of Roles, Networks and Trends

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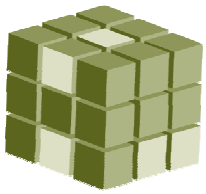

Health Promotion Ontario

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Introduction

With the publication of the *A New Perspective on the Health of Canadians* (the Lalonde Report) in 1974, the field of public health in Canada was introduced to a new specialty known as health promotion. New bureaucratic structures incorporating the term 'health promotion' were introduced at the federal and provincial level; post-secondary degree programs focused on health promotion emerged, as did job classifications focused on the new discipline.

Since that time, health promotion has emerged as both a recognized discipline and a well-defined approach to addressing public health issues. To better identify how the field of health promotion practice in Canada has evolved, the Public Health Agency of Canada (PHAC) funded Health Promotion Ontario, a professional organization representing the interests of health promoters working at public health units in Ontario, to carry out an environmental scan of the scope of health promotion practice and existing professional organizations and the discipline of health promotion across Canada. The results of this scan are presented in the following report.

The report is divided into six sections:

- **Section 1** provides an overview of the definitions defining both health promotion and the scope of health promotion practice in Canada
- **Section 2** provides an overview of the key organizations employing health promoters in Canada
- **Section 3** describes the professional organizations and networks that support health promotion practice and represent the interests of health promoters in Canada.
- **Section 4** provides an overview of the roles and responsibilities assumed by health promotion practitioners in Canada, including a summary of the current and emerging work on health promotion competencies.
- **Section 5** reviews the key trends and issues affecting the nature and scope of health promotion practice in Canada.
- A concluding section with some recommended next steps PHAC can take to strengthen health promotion-focused networks and associations and support the development of specific competency skills for health promoters.

The information presented in the report was compiled through a review of relevant literature, a search of relevant organizational websites and documentation and interviews with a number of key informants. It should be noted that the overview of key organizations presented in Section 3 is limited to those with an explicit mandate to focus on health promotion per se. Similarly, the overview of relevant roles and job titles in section 4 focused primarily on positions containing the term. There are numerous other organizations in the public, private and community not-for-profit sector that carry out health promotion work and engage the services of health promoters. However, the intent of the scan was to focus on groups, organizations and roles with a broad, general

health promotion mandate rather than those focusing on specific health issues or determinants (e.g., physical activity, diabetes or housing).

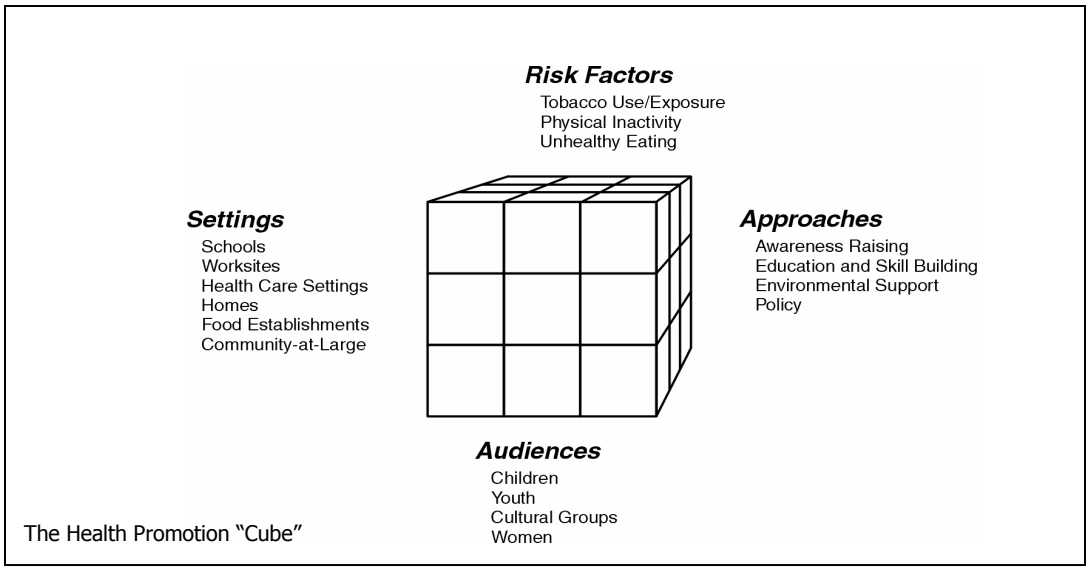
It is hoped that this report will help to increase understanding of health promotion practice in Canada. To better appreciate the value-added of health promotion, it is first necessary to clarify how the concept is defined.

Section 1: Definitions of Health Promotion in Canada

The most commonly accepted definition of health promotion in Canada is the definition adopted in the *Ottawa Charter for Health Promotion* (1986), which is widely considered to be the seminal 'blueprint' for health promotion practice. The *Ottawa Charter* defines health promotion as "the process of enabling people to increase control over and improve their health." This definition is premised on the understanding that both social conditions and personal actions determine health. Accordingly, health promotion activities move beyond disease prevention and health education to address social change, institutional change and community change in addition to changes in the behaviours of individuals.

As an approach to addressing health issues, health promotion is central to all aspects of public health science and practice. Health promotion practice encompasses the five action areas of the *Ottawa Charter*: building healthy public policy (e.g., bicycle helmet legislation), creating supportive environments (e.g., banning junk food in elementary schools), strengthening community action (e.g., supporting community coalitions taking action on homelessness), developing personal skills (e.g., healthy parenting programs), and re-orienting health services.

The action areas of the *Ottawa Charter* form the basis for the broad continuum of health promotion practice. As illustrated by the Health Promotion Cube, a schematic diagram developed to guide health promotion practice in Ontario (Ontario Ministry of Health, 1991), health promoters determine the optimal mix of approaches and strategies for addressing health issues within a broad range of settings.



The Health Promotion "Cube"

When considering the role of definitions in setting parameters for health promotion practice, it's important to note that, given the impact of social, economic and environmental factors on the health of individuals and communities, health promotion cannot be confined to traditional health education initiatives focused on health-related behaviours such as smoking, physical activity and healthy eating. To truly optimize the health and well-being of all Canadians, health promotion practice must encompass strategies addressing the determinants of health, such as income inequality, housing, education, transportation, early childhood development, community planning and the environment.

In an effort to guide the development of health promotion practice in Canada, the Canadian Public Health Association undertook a two-year consultation process with over 1,000 participants (Canadian Public Health Association, 1996). The resulting document, *Action Statement for Health Promotion in Canada*, identifies seven strategic principles guiding health promotion practice:

1. Health promotion addresses issues in context. It recognizes that many individual, social, and environmental factors interact to influence health. It searches for ways to explain how these factors interact in order to plan and act for the greatest health gain.
2. Health promotion supports a holistic approach that recognizes and includes the physical, mental, social, ecological, cultural and spiritual aspects of health.
3. Health promotion requires a long-term perspective. It takes time to create awareness and build understanding of health determinants. This is true for organizations as well as for individuals.
4. Health promotion supports a balance between centralized and de-centralized decision-making on policies that affect people where they live, work and play.
5. Health promotion is multisectoral. While program initiatives often originate in the health sector, little can be done to change unhealthy living conditions and improve lifestyles without the support of other people, organizations and policy sectors.
6. Health promotion draws on knowledge from a variety of sources. It depends on formal knowledge from the social, economic, political, medical and environmental sciences. It also depends on the experiential knowledge of people.
7. Health promotion emphasizes public accountability. Those providing health promotion activities need to be accountable and to expect the same commitment from other individuals and organizations.

The years immediately following the release of the Ottawa Charter witnessed the expansion of health promotion, both as a profession and a field of practice. For the first time, health and social service organizations, such as public health units and community health centres, began staffing positions as "health promoters". Provincial governments re-organized their bureaucratic structures to include health promotion and funded a series of health promotion projects at the provincial and community level. The following section provides an overview of the organizations employing health promoters in Canada.

Section 2: Organizations Employing Health Promoters in Canada

Public Health Agency of Canada

The Canadian government has long been a leader in supporting the development of health promotion policies and emerging best practices. In response to the Lalonde report, the Canadian government established a Health Promotion Directorate within the (then) federal department of National Health and Welfare in 1978. The original Directorate, the first such bureaucratic structure of its kind in the world, was organized around healthy lifestyle issues with a focus on smoking and nutrition. Over the following decade, branches of government dealing specifically with health promotion were put in place in a number of Canadian provinces and other jurisdictions; most of these were based, to some extent, on the original Canadian model.

More recently, the federal government's commitment to supporting health promotion was re-affirmed in 2004 with the creation of the Public Health Agency of Canada. The mission of the agency is "to promote and protect the health of Canadians through leadership, partnership, innovation and action on public health." Focused on effective approaches to prevent chronic disease and respond to public health emergencies and infectious disease outbreaks, the Public Health Agency of Canada works closely with provinces and territories to keep Canadians healthy while reducing pressures on the health care system.

The branch of the agency dealing with health promotion, Health Promotion and Chronic Disease Prevention, works with stakeholders at all levels to provide national and international leadership in health promotion, chronic disease prevention and control. The branch includes the Centre for Health Promotion, which is responsible for implementing policies and programs that enhance the conditions contributing to healthy development. For example, the Centre manages the Canada Prenatal Nutrition Program, a low birth weight prevention initiative that directs food supplements to low-income expectant mothers, as well as the Community Action Program for Children, which provides a range of activities supporting healthy child development and parenting skills. The Centre acts on the determinants of population health through programs addressing healthy child development, active living, families, aging and lifestyles, public information and education (through the Canadian Health Network) as well as issues related to rural health.

Provincial Governments

As the following table indicates, the majority of provinces deliver community-level health promotion programs through regional health authorities with public health and health promotion integrated with primary and tertiary health care services. The notable exception is Ontario, which delivers health promotion programs through a province-wide network of 36 public health units, which are funded through a cost-shared arrangement between the province and the municipal/regional tier of government. It's also important to note that Ontario is the only jurisdiction in Canada where the delivery of certain health promotion initiatives is mandated by the province; mandated public health services in most other regions of Canada are limited to health protection.

Four provinces, Saskatchewan, Manitoba, Ontario and Nova Scotia, have established provincial ministries dedicated to health promotion. Two of these ministries (Ontario and Nova Scotia) were initiated over the past year, and are still in the process of defining their respective mandates and setting strategic and programmatic priorities. To date, the Ontario Ministry of Health Promotion, which was created in June 2005, has established four strategic priorities: smoke-free Ontario (a multi-component, province-wide tobacco cessation initiative), healthy and active living, injury prevention and mental health and addictions.

In provinces operating under a regional health authority model, most of the large urban centres (e.g, Vancouver, Edmonton, Calgary and Montreal) have well-defined public health departments employing health promoters. In smaller centres, health promotion staff are distributed geographically, often reporting to generic managers. There is some evidence that the integration of health promotion programming within a regional health authority model (or variant) may affect both the breadth of programming as well as the level of dedicated resources A more detailed discussion of this issue is provided in Section 5 of the report.

Several provinces, most notably Saskatchewan, Ontario and Quebec offer community health promotion programs through provincially-funded networks of community health centers (CLSCs in Quebec). These organizations were designed to serve marginalized communities in inner-city or isolated rural areas. The health promotion programs offered through these organizations are not mandated and vary according to local needs. In December 2004 all CLSCs in Quebec were integrated into province-wide local service networks.

Table 1: Provincial Infrastructure for the Delivery of Health Promotion Services

Province	Relevant Ministries	Structure(s) for Delivery of Community-Level Health Promotion Programming
British Columbia	Ministry of Health	Regional Health authorities (5)
Alberta	Ministry of Health and Wellness, Department of Public Health	Regional Health Authorities (9)
Saskatchewan	Ministry of Health Ministry of Healthy Living Services	Regional Health Authorities (12) community health centres
Manitoba	Ministry of Health Ministry of Healthy Living	Regional Health Authorities (11)
Ontario	Ministry of Health and Long-Term Care, Pubic Health Division Ministry of Health Promotion	36 public health units 60 community health centres
Quebec	Ministre de Sante et Services Sociaux	95 local service networks
New Brunswick	Ministry of Health, Public Health and Medical Services Branch	Regional Health Authorities
Nova Scotia	Department of Health Department of Health Promotion and Protection	District Health Authorities (9)
Prince Edward Island	Department of Health, Population Health Division	
Newfoundland	Department of Health and Community Services	Regional Health Authorities (4)

Health-Related Non-Government Organizations (NGOs)

Canadian health promoters also work for health-related NGOs with issue-specific mandates, such as the national and provincial Heart and Stroke Foundation and Canadian Cancer Societies. The roles of health promoters working for these organizations includes health education, community mobilization, coordinating communication campaigns, referrals, information and knowledge exchange and advocacy.

Section 3: Health Promotion Professional Organizations

Health Promotion Ontario (public health)

Health Promotion Ontario (HPO) is a network of public health professionals working for public health departments and units in Ontario. The mission of HPO is to support the development of public health activities based on health promotion philosophy, practice and research.

Active since 1987, HPO members have been working to support each other by sharing resources and professional development opportunities. HPO holds an annual conference and conducts ongoing advocacy for the development of health promotion capacity in Ontario. In the winter of 2005, HPO released ***Health Promotion Ontario: Fulfilling the Promise***, a discussion paper with recommendations for strengthening health promotion programming capacity in Ontario (Feltracco and Wilkerson, 2006)

A number of HPO's activities focus on ensuring the recruitment of individuals with appropriate skill sets for health promotion work in Ontario. HPO has also played an active role in the development of professional core competencies for the public health workforce (Moloughney, 2006). In addition, HPO maintains an inventory of sample job descriptions for health promoters and plays an advisory role in the development of courses and other training opportunities for health promoters. HPO maintains a website for the purpose of information and resource sharing. HPO has also met formally and informally with the new Ontario Ministry of Health Promotion. As a constituent society of both the Ontario Public Health Association (OPHA) and the Association of Local Public Health Agencies (alPHa), HPO also represents the interests of health promoters within the larger public health sector.

Community Health Promotion Network, Atlantic Region

The Community Health Promotion Network, Atlantic Region is a voluntary organization that exists to share health promotion information among individuals, groups and communities in the Atlantic provinces. The Network is premised on the values of community development, mutual support and the vision of members helping one another.

Through a number of communication channels, including the maintenance of a member-accessed website and quarterly newsletter detailing health promotion developments in Nova Scotia, the Network provides its members with access to health promotion information, resources and people across the Atlantic Region. Members also have the opportunity to participate in on-line discussion about health promotion issues. The Network has recently become active in project coordination through its sponsorship of a summer institute on family safety issues.

British Columbia (BC) Coalition for Health Promotion

The BC Health Promotion Coalition is a diverse group working towards an enduring source of funding for health promotion activities inspired and implemented by communities in British Columbia. The Coalition envisions a fair and equitable process through which people at the grassroots can more readily access funds to carry out the work that is important to them in improving their health and quality of life.

As is the case with Health Promotion Ontario, the BC Coalition for Health Promotion is dedicated to strengthening the programmatic base for health promotion and building health promotion capacity in its home province. To this end, the Coalition released a discussion paper, ***A Health Promotion Foundation in B.C. Implementation Plan*** in August 2004. The Coalition has also published a report on financing health promotion in B.C and maintains a website with relevant health promotion links.

Canadian Consortium for Health Promotion Research

A network of sixteen health promotion research centres, the Canadian Consortium for Health Promotion Research is dedicated to enhancing health promotion research, policy and practice in Canada through linking research, capacity development and information dissemination. The Consortium has advocated for increased resources for health promotion research at the federal level, and has produced several documents outlining the state of research and knowledge transfer in Canada, including a review of methods used to synthesize health promotion evidence (Jackson et al., 2001). While it has played a modest role in raising the stature of health promotion research in Canada, the Consortium lacks core funding and has not been active in recent years.

Alberta Consortium for Health Promotion Research and Education

The Alberta Consortium for Health Promotion Research and Education (ACHPRE) is an association of province-wide health promotion research centres, which focuses on advancing health promotion, research, education and dissemination to inform policy and improve the health of Albertans. The Consortium works with the Alberta Ministry of Health and wellness and other partners, to maintain *Health and Action*, an on-line clearinghouse database of health promotion, injury prevention and population health programs and resources in Alberta.

Ontario Health Promotion Resource System

Funded by the Ontario Ministry of Health Promotion, the Ontario Health Promotion Resource System (OHPRS) supports health promotion in Ontario through a network of 23 resource centres that provide training, consultation, print and electronic resources, network building opportunities and referrals. The OHPRS includes resource centres mandated to address specific health issues and concepts, such as heart health, physical activity, nutrition, healthy communities and self-help/mutual aid, as well as more generic resource centres focused on skills and capacity building, such as the Ontario Prevention

Clearinghouse and the Health Communications Unit. OHPRS is governed by a Coordinating Committee comprised of resource centre representatives as well as quarterly forums attended by all OHPRS members. In 2005 the OHPRS initiated discussions about expanding its role to include advocacy for health promotion.

One of the more popular services OHPRS provides to health promoters in Ontario is the Ontario Health Promotion Email Bulletin, a weekly electronic health promotion newsletter launched in 1997. The Bulletin currently has over 5,000 subscribers and has become a valued source of information on current developments and best practices in the field of health promotion.

Health Promotion Clearinghouse (Nova Scotia)

Formally launched in 2001, the health promotion clearinghouse is a resource system aimed at supporting the work of volunteers and staff by providing timely access to health promotion resources and expertise that exists in Nova Scotia and beyond. Components of the Clearinghouse include a paid coordinator to answer resource questions, a toll free #, and extensive resource website, resource lists on various topics and information on health promotion resources, events, learning opportunities and jobs/funding opportunities.

Association of Ontario Health Centres

The Association of Ontario Health Centres (AOHC) represents the collective interests of community health centres, Aboriginal health access centres and other no-profit, community-governed, multi-disciplinary health care organizations. AOHC supports two networks of health promoters based at Ontario CHCS: one in the greater Toronto area and one in eastern Ontario Meetings of these Networks are informal in nature, hosted by community health centres, and focused on information sharing, problem solving and practice reflections.

Canadian Public Health Association

Established in 1912, The Canadian Public Health Association (CPHA) is a national, not-for-profit organization comprised of health professionals from over 25 health disciplines. CPHA is active in conducting and supporting health and social programs, both nationally and internationally. CPHA works in partnership with federal and provincial government departments and international agencies and the private sector in conducting public health research and supporting the delivery of public health initiatives. CPHA also plays a lead role in advocating for stronger public health infrastructure and the development of healthy public policies. CPHA hosts and annual conference and publishes a bi-monthly refereed academic journal as well as a quarterly newsletter.

For many years a position on the CPHA board was earmarked for a health promotion representative. However, this practice was abandoned with the adoption of a new board governance model starting in 2005. A question determining interest in health promotion

is a standard item on the form for new and returning CPHA members, but there have been only sporadic attempts to recruit these individuals into a network or keep them informed of health promotion developments.

As a signatory to the *Ottawa Charter for Health Promotion* in 1986, CPHA played an instrumental role in defining health promotion and setting parameters for health promotion practice. More recently, CPHA developed an Action Statement for Health Promotion in Canada including priorities for action (CPHA, 1996). CPHA was also involved in the development of public health workforce core competencies (Joint Task Group on Public Health Human Resources, 2005).

Provincial/Territorial Public Health Associations

The interests of health promoters are also represented by eleven provincial/territorial public health associations. Nine of the eleven associations are independent, incorporated organizations; the remaining two, representing New Brunswick/Prince Edward Island and North West Territories, Nunavut, operate as branches of the Canadian Public Health Association.

Section 4: Roles and Responsibilities of Health Promoters

With the introduction of *A New Perspective on the Health of Canadians* (the Lalonde report) in 1974, health promotion emerged as a distinct field of practice. The introduction of post-secondary degree programs in health promotion was another indicator of the interest generated by the Lalonde report. The first such program in Canada was established at the University of Toronto in 1979.

The years immediately following the release of the *Ottawa Charter for Health Promotion* in 1986 witnessed the expansion of health promotion as both a field of practice and a viable career option. For the first time, health and social service organizations created positions with 'health promotion' embedded in the job title. By 2005, the Public Health Human Resources Joint Task Group, a joint federal, provincial and territorial committee developing core competencies for public health practitioners, recognized health promotion as a distinct discipline within public health

A review of compiled job descriptions and a keyword search through the archives of the Ontario Health Promotion Email Bulletin, a key venue for advertising career opportunities in health promotion, generated the following job classifications for health promoters:

- Health promotion consultant
- Health promotion information specialist
- Health promoter
- Health promotion coordinator
- Health promotion manager
- Health promotion officer

It should be noted that the above list is by no means comprehensive. There are many individuals, both within and outside of the public health sector, with other job titles who do health promotion as part of their work. This underscores the complexity of identifying and defining the scope of health promotion practice.

When considering the scope of health promotion practice, it's important to note that health promotion practice can occur at different levels. While some "health promoters" are engaged primarily in front-line work involving community development or coalition support, others function as planners or specialists by applying health promotion concepts and strategies to a range of different programs. A growing number of health promoters have assumed managerial positions, which in some instances, has enabled them to apply health promotion principles at the organizational level.

Health promoters working in the public, private and not-for-profit sector assume multiple roles, including educator, communicator, planner, evaluator, researcher, manager, community mobilizer, coalition builder, facilitator and advocate for policy change. In recent years, work on core health promotion competencies has helped to further define these roles.

A key indicator of the acceptance of health promotion as a specialty within public health has been the introduction of skills-based criteria, or competencies, setting parameters around health promotion practice. The University of Toronto MHSc program in health promotion states that all health promoters should possess the following requisite skills:

Build and work in partnerships

- To develop a mutual learning relationship with partners (sharing knowledge, learning from the others experience, local knowledge etc…)
- To stimulate social support networks
- To build coalitions and stimulate intersectoral collaboration in the health settings.
- To act as a liaison between consumer groups and individuals and health care provider organizations

Facilitate community development

- To construct a dialogue with the community based on trust.
- To identify the community local capacities and strengthen them.
- To identify relevant and innovative experiences in the community that could be analyzed and disseminated
- To identify and collaborate with health promotion stakeholders (e.g, church, local schools, community associations, unions etc..)

Conduct program planning and research

- To use a participatory approach to conduct planning or research
- To use appropriate qualitative and quantitative methods
- To facilitate a needs assessment by the community
- To build new knowledge based on health promotion practice
- To evaluate HP programs in the field.

Use communication & social marketing tools

- To develop health communication material in an accessible language (journals, folders, newspapers, radio programmes) in partnership with other organizations.
- To elaborate campaigns of sensitization towards health issues in partnership with social development agencies, NGO's and local government
- To utilize a wide range of techniques for communicating health information and health promotion needs.
- To use culturally sensitive communication methods and techniques.
- To encourage behavioral change.

Engage in social & political action

- To be able to conceptualize, orient, and facilitate:
- Organizational change

Advocacy related to health issues
Participatory planning

- Analyze social, cultural, economic and political factors that influence health, including deepening the social analysis regarding systemic determinants of health inequalities (economic and social policies, institutional practices, systemic racism/classism/ageism/ableism, gender discrimination, etc)
- Determine priority areas of need for health promotion
- Recruit community organizations, resource people, and potential participants for support and assistance in program planning.

General Academic Skills

- Communication effectiveness (oral & written)
- Research skills (using a variety of methods of data collection & analysis)
- Critical appraisal of the literature (research evidence, argumentation); capable of being informed consumers of research
- Creativity and innovation

A more recent set of skills-based criteria of interest to health promoters is Canadian Public Health Workforce Core Competencies (Moloughney, 2004). Developed by the Federal-Provincial-Territorial Public Health Human Resources Joint Task Group, this document provides a comprehensive set of public health competencies and skill sets divided into seven domains: core public health sciences, analysis and assessment, policy development and program planning, partnership and collaboration, communication, socio-cultural competencies and leadership and system approaches.

Though not specific to health promotion, the competencies include many, if not all, of the relevant skills and capacities expected of health promoters. For example, the Analysis and Assessment Domain subset of the competencies states that all public health practitioners, including health promoters, should be able to:

- Define a problem
- Identify relevant and appropriate data and information sources. Collect accurate quantitative and qualitative primary data when secondary data is unavailable
- Identify community assets and available resources
- Determine appropriate uses and limitations of both quantitative and qualitative data
- Evaluate the integrity and comparability of data and identify gaps in data sources
- Obtain and interpret information regarding risks and benefits to the community
- Partner with communities to validate and attach meaning to collected quantitative and qualitative data
- Make relevant inferences from quantitative and qualitative data
- Recognize how the data illuminates ethical, political, scientific, economic, and overall public health issues
- Identify relationships, trends, and patterns in health assessment information and make appropriate recommendations on further investigations or actions that should be taken
- Understand cost-effectiveness, cost-benefit, and cost-utility analyses
- Apply ethical principles to the collection, maintenance, use, and dissemination of data and information
- Apply data collection processes, information technology applications, and computer systems storage/retrieval strategies

Another set of competencies for health promotion is the sample job description for a health promotion officer, one of the most widely used job titles for health promotion practitioners, developed by Health Promotion Ontario. This description notes that a health promotion officer should be able to:

- Demonstrate knowledge necessary for conducting health promotion that includes:
    - Applying a determinants of health framework to the analysis of health issues.
    - Applying theory to health promotion planning and implementation
    - Applying health promotion principles in the context of the roles and responsibilities of public health organizations
    - Describing the range of interventions available to address public health issues

- Conduct a community needs assessment for a specific issue that includes:
    - Identifying behavioural, environmental and organizational factors that promote or compromise health
    - Identifying relevant and appropriate data and information sources
    - Identifying community assets and resources
    - Partner with communities to validate collected quantitative and qualitative data

- Contribute to policy development that includes:
    - Describing the health, economic, administrative, legal, social and political implications of policy options
    - Stating policy options and writing clear and concise policy statements
    - Recommending an appropriate course of action.

- Plan appropriate health promotion programs that includes:
    - Identifying, retrieving and critically appraising the relevant literature
    - Developing a component plan to implement policy including goals, objectives and implementation steps
    - Monitoring and evaluating implementation of interventions
    - Contributing to the development of a program budget

- Engage in partnership and collaboration that includes:
    - Establishing and maintaining linkages with community leaders and other key stakeholders
    - Utilizing leadership, team building, negotiation and conflict resolution skills to build community partnerships
    - Advocating for individuals and communities on aspects that will improve their health and wellbeing

- Communicate effectively with clients and other professionals that includes:
    - Providing health status, demographic, statistical, programmatic, and scientific information tailored to professional and lay audiences
    - Applying social marketing principles to the development, implementation and evaluation of health promotion programs
    - Using the media, advanced technologies, and community networks to receive and communicate information
    - Interacting with, and adapting policies and programming that responds to the diversity in population characteristics

- Organize health promotion interventions that includes:
    - Training and coordinating program volunteers
    - Describing scope of work in the context of organization's mission and functions
    - Contribute to team and organizational learning

A common feature of these competency statements is a strong ability to analyze health issues from a health promotion perspective. Specifically, health promoters should be able to analyze the nature of a health issue or problem and provide expert analysis and advice on how to address it through the appropriate mix of health promotion strategies, including community mobilization, social marketing, health education, advocacy, policy development and organizational change. The combination of knowledge, lived experience and a solid grasp of the 'art and science' of health promotion practice constitute the value-added that health promoters bring to the field of public health.

Section 5: Trends and Issues in Health Promotion

Health Promotion and Regionalization

One of the primary trends in the administration of health services over the past decade is the creation of integrated health organizations based on regional boundaries. With the notable exception of Ontario, all regions of Canada had integrated public health and health promotion services into some form of regional health authority model by 2005.

The impact of regionalization on public health (including health promotion) capacity was the subject of a 2004 study by Dr. Brent Moloughney. The study methodology consisted of key informant interviews in six provinces with regional health authority models (British Columbia, Alberta, Saskatchewan, Quebec, New Brunswick and Nova Scotia), as well as a more in-depth analysis of one province, Nova Scotia, that had recently completed a health system transformation to a regional model (Moloughney, 2005).

The study found that, on balance, the process of regionalization in Canada has generally not been implemented in a manner conducive to health promotion and the broader public health system. While there were some potential positives arising from regionalization, such as an opportunity to increase system-wide emphasis on prevention and health promotion, the adoption of regional delivery models has been mainly associated with threats and challenges to the sustainability of public health. Most of these challenges appear to stem from the fact that regionalization has focused on the integration of institutional, tertiary care services with public health added as an afterthought. Consequently, the critical success factors needed to ensure optimal capacity for health promotion and disease prevention functions were never given proper attention (Moloughney, 2005).

In his analysis of the impact of regionalization on public health, Moloughney (2005) summarized his findings into three categories: the 'good', the 'potential' and the 'not so good'. The mention of 'potential' benefits acknowledges that a regional delivery model is a relatively new innovation in many parts of Canada, so its full impact on health promotion capacity (negative and otherwise) remains to be seen.

'Good' and 'potential' opportunities for health promotion in an integrated regional model of service delivery include better system-wide coordination in response to health promotion priorities; an opportunity to influence strategic priorities at the executive level, and more coordinated access to population data and analysis guide planning, program and policy development. However, these opportunities are limited by a lack of health promotion expertise and capacity in many regions, as well as the fact that the majority of Canadian provinces and territories do not have mandated public health programs beyond health protection.

The challenges, or 'not so good' outcomes, associated with the integration of public health into regional delivery models include the loss of public health support services, the diversion of public health resources (rent, equipment and staff) to other sectors of the health care system, a lack of accountability mechanisms and performance standards,

a lack of 'critical mass' for many areas of public health practice, and the absence of an explicit mandate for public health/health promotion.

Moloughney concludes that in spite of some potential opportunities, many of which have yet to be realized, the integration of public health into regional models has led to a "hollowing out of provincial level capacity" for health promotion and disease prevention. However, Moloughnney notes that the weakening of public health system functioning and capacity in many areas of Canada is not attributable to regionalization per se, but rather to the lack of attention to critical success factors.

As Ontario proceeds with the coordination of health service delivery and administration through fourteen Local Health Integration Networks (LHINs), it will be interesting to see if any possible move to coordinate the administration and delivery of public health services within the LHIN boundaries will be guided by lessons learned from the impact of regionalization in other provinces. At present, the potential impact of LHINs on health promotion services, which continue to be delivered through a separate network of locally-governed public health units, remains to be seen.

Core Competencies for Health Promoters

There is increased support for the development of professional, competency-based standards to guide public health workforce renewal in Canada. Interest in core competencies for public health practice in Canada first surfaced in early 2004 through a series of system stakeholder regional workshops on public health education. Since that time, there has been significant activity among a range of public health professions to define the set of requisite or "core" competencies for their discipline. These include public health nurses, public health inspectors and public health epidemiologists as well as health promoters.

A review of health promotion competency work commissioned by Health Promotion Ontario revealed several relevant pieces of work, including health promotion competency criteria developed in Australia, New Zealand, the United States and Canada. The advanced state of work in this area (some of which is summarized in Section 4 of this report) led the author of the review to conclude that there was a substantial amount of work available to serve as a starting point for the development of standardized Canadian health promotion competencies without having to 'start from scratch' (Moloughney, 2006).

The achievement of consensus on health promotion competencies will inevitably raise issues regarding training, continuing education opportunities, valuing experience and accreditation. For example, if health promoters are expected to possess a particular set of competencies, how should they be obtained? What competencies are expected upon entry to the health promotion workforce vs. 1-2 years of experience? What are the implications for training and continuing programs? Will there be a process for monitoring attainment of the competencies by existing and incoming health promotion practitioners? Will there be a process for revising the criteria over time as the knowledge

base for health promotion evolves? Will a list of health promotion competencies eventually constitute the criteria for either voluntary or mandatory accreditation?

These questions are not new to health promotion, nor can they be answered in the absence of extended consultation between health promoters and other relevant stakeholders. But there needs to be some recognition that the development and adoption of a standard set of health promotion competencies will surface these broader issues. As a relatively new discipline within the public health sector, health promotion can be informed by the experience of other discipline groups that have had to deal with these issues through the development of their respective competency standards.

Health Promotion in the Context of Public Health Renewal

During the opening decade of the 21st century, Canadians were hit with a series of crises that revealed the erosion of public health services following years of cutbacks and under-funding. Events such as the contaminated water crisis in Walkerton and the outbreak of Severe Acute Respiratory Syndrome (SARS) in Toronto demonstrated that concerns about the systemic neglect of essential services could not, contrary to prevailing government ideology, be dismissed as self-serving advocacy from (so-called) 'interest groups'.

The focus on public health renewal in the wake of these crises offers uncertain implications for the future of health promotion in Canada. Numerous expert review committees and reports, some of which were commissioned in the wake of the above-noted crises in Ontario, lay out competing blueprints for a rejuvenated public health system. While there is much to commend in these initiatives, there is an undue emphasis on communicable disease control at the expense of health promotion, chronic disease prevention and other core functions of public health. For example, the "The SARS Commission Interim Report: SARS and Public Health" by the Honourable Mr. Justice Archie Campbell, Commissioner (2004), makes the following assertion:

> *"While it would be wrong to downgrade the long-term importance of health promotion and population health, the immediate threat posed by any infectious outbreak requires that a dominant priority must be given to protecting the public against infectious disease. It does not disrespect the advocates of health promotion to say that the immediate demands of public safety require that public health, as its first priority, looks after its core business of preventing us from infectious disease." (Campbell, 2004, p. 12).*

One can readily understand the concerns underlying this viewpoint. It would, however, be a gross error of judgment to uphold infectious disease control as *the* single, over-riding 'core business' of a reformed public health system.

The ultimate strength of public health lies in its capacity to address the myriad of health issues affecting the entire population. Communicable disease prevention, while a critical priority of public health practice, should not be given precedence over public health efforts addressing tobacco addiction, childhood obesity, air quality and socio-economic

inequalities, to name but of a few of the key issues affecting the health and well-being of Ontarians. And to put the relative magnitude of health risks in perspective, Dr. Richard Schabas, the former Chief Medical Officer of Health for Ontario, noted that smoking kills as many Canadians as SARS did, *every eight hours* (Schabas, 2004).

Health promotion cannot be a marginalized component of an effective public health system. To fully meet the health needs of all Canadians, public health practice requires a complementary, sustainable balance of communicable disease prevention and health promotion skills and approaches.

Health Promotion Workforce Issues

Public health renewal efforts in Canada have focused attention on the strength and capacity of the public health workforce. As the *National Advisory Committee on SARS and Public Health* noted in its report "no attempt to improve public health will succeed that does not recognize the fundamental importance of providing and maintaining in every local public health agency across Canada an adequate staff of highly skilled and motivated public health professionals" (NACSPH, 2003). The achievement of this outcome requires an understanding and commitment to taking action on challenges related to recruitment and retention, leadership and mentorship and quality of working life.

To date, there has not been a comprehensive survey of the health promotion workforce in Canada. A recent survey of over 1,400 public health practitioners in Ontario (including health promoters) revealed a number of systemic workforce issues common to both health promoters and the broader public health system (Capacity Review Committee, 2005). These include:

- the relatively low profile of public health as a career option, which hinders the recruitment and training of public health professionals;
- job instability resulting from numerous funding and organizational changes over the past decade;
- a perception that some public health salaries are not competitive and a variance in salary levels between local public health agencies;
- few opportunities and little time for ongoing professional development;
- lack of career paths and opportunities for advancement.

The effective resolution of these workforce issues requires a range of complementary strategies ranging from greater marketing efforts to increase interest in public health careers to the publication of salary bands and enhanced resources for both entry-level training and professional development. The Capacity Review Committee, which commissioned the study noted above, felt that workforce issues in public health were best addressed through a comprehensive human resources strategy (Capacity Review Committee, 2006).

Health promoters may wish to assume a more proactive role in the identification and resolution of workforce issues affecting their discipline. As is the case with the development of core competencies, there is much to be learned from other public health disciplines that have extensive experience with advocacy on behalf of their respective workforces.

Broadening the Parameters of Health Promotion Practice: Work on the Social Determinants of Health

A large body of research has shown that poverty and income inequality are the greatest causes or *determinants* of health status. Simply put, low-income Canadians are more likely to die younger and suffer more illness than Canadians with higher income regardless of age, sex, race or place of residence (Second Report on Health of Canadians, 1999). Accordingly, one of the underpinnings of health promotion theory is the need to ensure that everyone has equitable access to the determinants of health, including food, income, employment, shelter, education and supportive social networks.

Yet in spite of the extensive knowledge attesting to the importance of the social determinants of health, the majority of the work performed by health promoters continues to focus on the promotion of healthy lifestyles. However, recent developments, both in Canada and internationally, suggest that this may be about to change.

One notable development is the World Health Organization's establishment of a Commission on the Social Determinants of Health. Created in March 2005, the Commission serves as the World Health Organization's vehicle to draw the attention of governments, civil society, international organizations, and donors to pragmatic ways of creating better social conditions for health. It is expected that the final report of the Commission will serve as a seminal blueprint for the development of health promotion programs and policies addressing the social determinants of health.

Among the Canadian provinces, Nova Scotia has arguably made the greatest progress in utilizing determinants of health research to guide planning and policy making. The emphasis on the determinants of health is made explicitly in one of the values statements of the Nova Scotia Department of Health, which "recognizes the need to consider the broader determinants of health as a means of improving the health of its population." The Department undertook a series of health impact analyses dealing with social determinants of health issues, such as VLT gambling, and actively collaborated with key stakeholders to further work on defining key determinants such as social exclusion.

Nova Scotia's pioneering work social determinants of health planning was recognized in 2004, when the Public Health Agency of Canada established its National Collaborating Centre for the Determinants of Health in Halifax. The Centre is mandated to work in close collaboration with researchers, the public health community and government and non-government organizations to examine ways of addressing the social determinants of health.

In Ontario, several health units have grappled with the implications of the social determinants of health for public health practice. For example, Waterloo Region Public Health Unit established an internal planning division focused on the determinants of health in 2000.

More recently, the upcoming revision of the *Mandatory Program Guidelines*, the document laying out the programs and services that all Ontario health units are expected to deliver, provides an opportunity to re-focus health promotion practice with a greater emphasis on the social determinants of health. The Sudbury and District Health Unit has acted on this opportunity by convening a two-day consensus-building workshop which culminated the development of a proposed framework to integrate the social and economic determinants of health into the public health mandate (Lefebvre, Warren, Lacle and Sutcliffe, 2006). The impact of these efforts on the scope of health promotion practice in Ontario remains to be seen.

Conclusion/Next Steps

Policy makers have long understood the promise of health promotion. Since the release of the *Lalonde Report* in 1974, a series of frameworks and vision statements have upheld this promise – the promise of health for all, reduced health care costs, the empowerment of individuals to assume control over the factors affecting their health and a more equitable society where access to the social determinants of health are within reach of everyone.

Yet this promise remained out of reach due to a lack of commitment by all levels of government. As noted in a 2005 position paper from *Health Promotion Ontario*

> *"a generation has passed while the concept of health promotion languished in half-realized projects and good intentions to become convenient health sector rhetoric." (HPO, 2005, p. 7).*

There is some indication, however, that the current policy environment demonstrates a renewed interest in health promotion. Over the past five years, innovations such as the creation of a Public Health Agency of Canada (PHAC), the establishment of provincial Ministries of health promotion and healthy living and the continued growth of the health-promotion networks and associations described in this report signals a new opportunity to re-energize health promotion practice.

As the key branch of the federal government with a mandate to support health promotion, the PHAC can strengthen the development of effective health promotion practice by:

- sponsor annual meetings or learning exchanges between the national and provincial/territorial health promotion networks and associations to foster a pan-Canadian dialogue on health promotion practice;
- support a consultative process for the development of specific competencies for health promotion practitioners;
- support the dissemination of this report as a starting point for initiating dialogue on key issues affecting health promotion practice

It is hoped that the preceding document will help to guide the development of health promotion practice and to assist health promoters in coming to terms with the trends and issues affecting their field of practice. Further discussion and collaboration between key stakeholders on the issues raised in this support will help to ensure a strong and viable health promotion system throughout Canada.

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Ottawa Charter for Health Promotion Ottawa: World Health Organization

Schabas, R. "Don't cry wolf on every flu." The Globe and Mail, Monday February 2, 2004, A11.

Appendix A: List of Canadian Health Promotion Organizations

Alberta Consortium for Health Promotion Research and Education
c/o Alberta Centre for Active Living
3rd Floor, 11759 Groat Road
Edmonton, Alberta
T5M-3K6
Contact: Karena Apps-Eccles, Project Manager
Tel: 780-427-6949
Email: **active.living@ualberta.ca**
Website: **www.health-in-action.org**

Association of Ontario Health Centres
1 Eva Road, Suite 220
Toronto, Ontario
M9C-4Z5
Contact: Adrianna Tetley, Executive Director
Tel: 416-236-2539
Email: **mail@aohc.org**
Website: **www.aohc.org**

British Columbia (BC) Coalition for Health Promotion
14-3497 Gibbins Road
Duncan, British Columbia
V9L-6C9
Contact: Ronnie Phipps, Core Team Member
Tel: 250-746-1797
Email: **bchpc@vcn.bc.ca**
Website: **www.vcn.bc.ca/bchpc**

Canadian Consortium for Health Promotion Research
c/o Centre for Health Promotion, University of Toronto
155 College Street, Suite 400
Toronto, ON
M5T-3M7
Contact: Dr. Suzanne Jackson
Tel: 416-978-1100
Email: **suzanne.jackson@utoronto.ca**
Website: **www.utoronto.ca/chp/CCHPR/index.htm**

Canadian Public Health Association
400-1565 Carling Avenue
Ottawa, Ontario
K1Z-8R1
Contact: Dr. Elinor Wilson, Executive Director
Tel: 613-725-3769
Email: **info@cpha.ca**
Website: **www.cpha.ca**

Community Health Promotion Network, Atlantic Region
Suite 129, Unit 50, Hamlyn Road Plaza
St. John's Newfoundland
A1E-5X7
Contact: Lisa Pike, Executive Director
Tel: 709-782-4685
Email: **lpike@cphna.ca**
Website: **www.chpna.ca**

Health Promotion Clearinghouse, Nova Scotia
Suite 209, City Centre Atlantic
1535 Dresden Row
Halifax, Nova Scotia
Contact: Carolyn Ploem, Coordinator
Tel: 902-494-1917
Email: **hpclearinghouse@dal.ca**
Website: **www.hpclearinghouse.ca**

Health Promotion Ontario
c/o County of Lambton Community Health Services
160 Exmouth Street
Point Edward, Ontario
N7T-7Z6
Contact: Kevin Churchill, Executive Committee member
Tel: 519-383-8331
Email: **kevin.churchill@county-lambton.on.ca**
Website: **www.hpoph.org**

Ontario Health Promotion Resource System
180 Dundas Street, Suite 1900
Toronto, Ontario
M56-1Z8
Contact: Sherri Anderson, Coordinator
Tel: 416-408-2249
Email: **ohprs@opc.on.ca**
Website: **www.ohprs.ca**