Health Promotion in Aotearoa New Zealand: The Way Forward
A Public Health Unit Manager's Perspective

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Purpose and Scope

The purpose of this paper is to create a "think-piece" to stimulate discussion and action towards the strengthening of the health promotion workforce in Aotearoa New Zealand, and to recommend strategies to support the development of a well-trained workforce with the skills and capability to lead health promotion into the future, at all levels. It is not an academic paper, but a piece of writing that expresses my own opinion on the issues facing health promotion in this country today. The paper has been requested by the Ministry of Health as part of their Public Health Workforce Development Programme and results from recommendations made at the Health Promotion Think-Tank held in Auckland in February 2006. The questions that emerged from that process are complicated and have perplexed people working in health promotion over the years. These questions include:

- How can access, cohesion and linkages in the development and delivery of health promotion be achieved?
- How can strong and diverse leadership in health promotion be developed and promoted?
- How can a strong focus on community development for the health promotion workforce be maintained?
- How can a strong focus on determinants of health and the reduction of health inequalities for the health promotion workforce be developed?
- How can the voice of health promotion within public health and primary care be strengthened?
- How can competence in the workforce for health promotion be built and ensured?
- How can cultural competence in the workforce for health promotion be built and ensured?

It is my intention to write this paper from a perspective of honesty, and respect for all my fellow colleagues in health promotion and the significant contributions

they bring. I do not pretend that there are easy solutions. If there are, I'm not aware of them. The solutions will be as complex as the issues we are trying to address, and will require a spirit of goodwill and cooperation across the sector.

The health and political environment in which health promotion currently operates presents some significant opportunities for both health promotion as a discipline, and its ability to significantly impact on health outcomes. I believe that unless health promotion rises up as a unified whole and meets these opportunities it risks further marginalisation and loss of voice, and the opportunity to have a major impact on the health of New Zealanders.

In order to consider and identify some responses to the questions listed above, I believe it is necessary to begin by providing a snapshot of what Health Promotion in Aotearoa New Zealand currently looks like, and what are the realities that exist for those of us who are immersed in it on a day-to-day basis. I will describe what this means from my perspective as a Manager within a Public Health Unit, and suggest from that perspective what some solutions might look like.

Under the Rock: The Issues

Some years ago I went on a school trip with my son's class as a parent helper. We went to Sumner beach to study rock pools at low tide. One of the exercises the children had to undertake that day was this: Find a rock and carefully lift it up. Describe everything you can see underneath that rock in your exercise book, and then without disturbing anything carefully replace the rock.

If we were to apply the same exercise to health promotion in Aotearoa New Zealand today, if some external person were to gently lift up the rock under which we all operate, and observe how we look, what we do, how we do it, where we do it and when we do it, what would he/she see? And how would he/she describe it. I believe he/she might record something like this:

Health promotion activities in Aotearoa New Zealand are fragmented and uncoordinated. Bits of health promotion are delivered by a wide range of people in a variety of different organisations and settings, some of which are formal and some informal. It is delivered by PHUs, NGOs, PHOs, community groups, and Territorial Authorities etc. A variety of different methods are used, there is often little or no communication between practitioners from different organisations, and therefore it is difficult to see if these activities are working towards common goals. It is also difficult to determine the impact many of these activities are having without digging deeper. The individuals that carry out health promotion activities have an enormous passion; this is evident by the high level of

commitment and the energy they apply to their work. They are often fiercely protective of the piece of health promotion they are involved in, and about the particular theory or method they are applying. Health promotion activities are delivered/practiced in a variety of ways, because there are many different aspects to health promotion. However it appears that among the individuals and organisations involved in health promotion delivery there is sometimes confusion and disagreement as to what health promotion actually is, and how it should be practiced. There are some deep divisions that the people trying to lead health promotion are unable to bridge. This is evident in the inability of the Auckland Think Tank to agree on a common understanding of what health promotion is.

It is not the purpose of this paper to delve into the history of health promotion in Aotearoa New Zealand; therefore we will acknowledge that this situation has developed over some time, and that there is a valid rationale to explain this. When we look at health promotion practice today, with a non-judgmental eye, it is obvious there are good reasons for this fragmentation, but I believe there is little value in dwelling on the past or delving too deeply into an analysis of it. As it looks today, we can clearly see some factors that are impacting on the situation. These factors include a lack of strong, nationally recognised leadership. Various organisations and individuals are considered by others, or display leadership. Some of this leadership is formal (as in appointed positions) and some informal (as in recognized skills and knowledge by the sector), however this leadership is not coordinated, nor do all the players in the field recognize it.

As well as a lack of leadership, there is no recognized body that sets professional standards and identifies specific qualifications for the profession. This poses a significant risk of health promotion becoming marginalized, more fragmented and not being recognized nationally as a credible voice.

Another key issue is the lack of an agreed set of goals and objectives which health promotion needs to achieve. The emphasis here is on the 'agreed' bit. The Ministry of Health has clearly identified health goals and objectives within the New Zealand Health Strategy, however not everyone practising health promotion agrees that these are the priorities that should be addressed.

There are also no agreed on objectives and strategies that clearly identify where health promotion itself wants to be in the future, or how it intends to get there. Without these how can we operate at all?

Because these key factors are currently missing from the health promotion environment, health promoters and those carrying out health promotion activities have difficulty in addressing the issues they are collectively required to

address. These issues include the increasing inequalities in health, and a growing national burden of preventable disease. By not being recognized by the wider health sector as a credible professional voice, health promotion is at risk of being minimised and sidelined.

Twelve Public Health Units (PHUs) deliver core public health services, including health promotion, over the length and breadth of the country. PHUs are attached to District Health Boards and funded directly through the Ministry of Health. Many of the PHUs provide services to more than one DHB, and the health promotion services they provide differ significantly between areas. Some of the services are delivered for historical reasons, others because of preference. Although there have been attempts by both the MoH and the PHUs to achieve consistency in contract specifications and service delivery, this has not yet been achieved. About 50% of all health promotion activities, a significant critical mass, are currently located within PHUs. Many health promoters working outside of the PHUs have begun their health promotion careers in PHUs, which are widely regarded as providing hands-on learning and experience.

The current political climate is conducive to health promotion. This is evident in the range of organisations that now have a responsibility to improve the overall health of population groups and communities. These include the changes in the health system that have created District Health Boards and Primary Health Organisations. The latter in particular provide ideal settings for some health promotion to occur, and I believe that ongoing development of this sector will lead to growth in health promotion activities occurring from here, but there is significant work to be done to build capacity in this sector. Territorial Authorities also have a responsibility for the health outcomes of the communities they serve through their legislative requirement to develop Long Term Community Council Plans. Again capacity building is required here. The health promotion that is based in Public Health Units can, and should, take key roles in developing capacity for health promotion approaches in these organisations, and in coordinating the activities of these organisations in their regions. The potential to impact on the social determinants of health through the development of health promotion approaches in these organisations is greater now than at any other time in our history. However, for this to occur we need to develop greater collaboration and synergy.

In addition it is vital to recognize that besides professional health promoters (those who are in paid employment to deliver health promotion) there are many health promotion processes taking place in the community, in a variety of settings and groups, which add enormous value. I do not know if we will ever be able to do a full 'stock-take' of all these people and activities, and it will be difficult to draw the line between the work that is carried out informally by these

groups and that which is carried out by specifically contracted organisations such as PHUs and NGOs. I do believe it is the responsibility of PHUs especially to provide capacity building, resource and support for this work, and even to deliver joint projects where this is appropriate.

The Ministry of Health's Public Health Workforce Action Plan is well under way and has identified 10 priority actions that are currently being addressed. These actions have the potential to have a positive impact on health promotion practice, and to address some of the issues raised. A common set of agreed competencies and professional standards are currently being worked on as part of this project, but these are for public health as a whole, not health promotion specifically (although they have considered the competencies developed by the Health Promotion Forum) and are still a way off. Until these are accepted by health promotion as a whole there will be ambiguity over what the competencies of health promotion are/should be.

A Public Health Unit's (PHU) Manager's Perspective

If the above is an unbiased description of health promotion as it currently exists, then managing health promotion in a PHU becomes a bit like navigating a tiny boat through a braided river, never being quite sure where, or if, any stream you're traveling on will connect back to the main body of water. The directions are vague and inconsistent, the start and finish lines keep changing, there is no need for a licence to paddle the boat, no clearly defined rules for the race, and the streams are all heading off into different direction. Yet there is a strong desire to continue paddling, a passion for getting to a point, and a hope that all the other little boats and their paddlers will arrive there as well.

So, from this perspective, how do we move forward? And what do we move forward towards?

These are my thoughts:

The nature of health promotion itself is one of facilitation and incorporation of all views, no matter how diverse. That is both its strength and its weakness, and means that many of the issues raised above remain unresolved by the sector itself, (if it was capable of doing so it would be safe to assume that it would have occurred by now, given the passion and commitment of the people working within it). At the Auckland Think Tank of health promotion leaders in February of this year there was a long discussion on what health promotion actually is, and the minutes show no resolution was achieved. As long as that is the case

there is little chance of the sector itself addressing these issues any time in the foreseeable future.

If there is anything we can all agree on it is the issues themselves. We all want cohesion, strong leadership, a competent workforce and a strong recognized voice. We all want health promotion to be taken seriously. So what needs to happen to make these a reality? I believe it is the following:

1. Common agreement on what health promotion is: what informs it (The Treaty of Waitangi, The Ottawa Charter, The Jakarta Declaration, The Bangkok Charter, the determinants of health and health inequalities etc.), how it is delivered/practiced (community development, input into policies and submissions, health education, resources development and distribution, social marketing, in settings etc.). It needs to be broad and inclusive to capture the wide range of activities that are being carried out. There needs to be acknowledgement and recognition that all the various strands are valid and valued, even by those who practise it differently. The need to achieve this is urgent if we want to seize the opportunities that currently exist.

2. There needs to be strong national leadership that is recognized by <u>all</u> health promotion practitioners. This could take the form of an organisation/ body/ role that has the capacity to work across the sector to establish commonly held standards and codes of practice and develop strategic goals and objectives for the profession. Where such a role would sit needs to be determined. In my opinion the Ministry of Health needs to set up an independent body with clear terms of reference, which is neither a government agent nor an NGO. It is my understanding that such a body is also required for health protection. Perhaps this role could be combined into an independent public health body with subgroups for health promotion and protection. Both health promotion and protection could be practiced from a wider public health perspective and still remain as distinct approaches. This would strengthen the synergy applied to public health outcomes.

3. Nationally consistent and recognized competencies and a qualifications framework that reflects these. These are currently on the agenda of, and being developed, as part of the Public Health Workforce Development Project.

So who should drive this? Clearly this won't happen spontaneously. At this point in time I believe the Ministry of Health's Public Health Directorate, as the funder of the bulk of health promotion programmes is the only appropriate driver. I say this not because I think that it is necessarily their role, but because present circumstances preclude any current providers from taking that role. The driver of these processes must be in a role that is neutral to the politics of health promotion providers, and be acceptable to all. The Ministry could contract out this role, or second someone with the skills to achieve it.

With the above points in mind I would answer the questions posed at the beginning of this paper as follows:

- **How can access, cohesion and linkages in the development and delivery of health promotion be achieved?**

Through coordinated planning and service delivery. We are a very small sector in a small country. We should be able to collectively work towards the same outcomes: the reduction of inequalities in health and the reduction of preventable diseases to name two obvious ones that come to mind. The current PHU/NGO sector works against this as each organisation develops its own services.

- **How can strong and diverse leadership in health promotion be developed and promoted?**

Through the development of the wide variety of activities that are loosely termed as health promotion, into a recognized and accepted, comprehensive set of processes that are carried out to common standards and codes of practice. Leaders will emerge in the various strands of health promotion (as indeed they do now). The emerging and existing leaders need to have access to quality, recognised training, and formalised support such as scholarships and mentoring. They also need to have the ability to step out of their regular jobs to do this. It is important to distinguish leadership from management. Leadership in health promotion needs to occur at many levels.

- **How can a strong focus on community development for the health promotion workforce be maintained?**

Community Development is a valid and effective way to deliver health promotion in many settings. It is one of a number of health promotion methods, all of which have validity when applied at the right times for the right purposes. Within health promotion there needs to be a clear understanding of community development to prevent groups and communities from becoming dependent on the interventions or worker. True community development is empowering and develops self-determination,

which are values that strongly underpin health promotion. Successful community development results in health promotion handing over to the community and letting go. At the present time we also have inadequately developed capacity in communities to lead, make appropriate decisions and develop strategies. The challenges for health promotion are to up-skill and build capacity in these groups. Knowledge is the key to empowerment. If knowledge is securely retained within health promotion ranks community development will fail. If community development approaches are threatened, it is because of this, and because it is seen as being at odds with so called "issues" based work. I cannot think of a single health promotion service line or "issue" that could not be delivered from a community development perspective, providing sound planning and evaluation measures were in place, the community was involved in this process, and the objective of the programme was to empower the community to address the issue in a way that is appropriate to them.

How can a strong focus on determinants of health and the reduction of health inequalities for the health promotion workforce be developed?

I have yet to meet a health promoter for whom this has not been a focus. I have yet to see a contract for health promotion service delivery that does not specify this. It is a key focus of all formal and informal health promotion training that I am aware off. I believe there already is a strong focus within the health promotion workforce. What we need is agreement on what we are going to do about it.

How can the voice of health promotion within public health and primary care be strengthened?

As stated earlier, to have a strong voice health promotion needs to be a credible sector with recognised standards of practice and strong leadership.

How can competence in the workforce for health promotion be built and ensured?

I believe that this work is underway with the Public Health Workforce Development Project. This work would be greatly enhanced and gain significantly more momentum if the fragmentation in the sector was diminished.

How can cultural competence in the workforce for health promotion be built and ensured?

This too is a key component of the Public Health Workforce Development Project. Specific pieces of work have been contracted to Maori and Pacific groups. It is fundamental to reducing inequalities and increasing Maori health gain that all training and development programmes aimed at the

health promotion workforce incorporate elements that will develop cultural competence. Aligning training programmes to nationally consistent competencies that include cultural components will go a long way towards this. We also must not forget that we have a responsibility to apply an ethnic/cultural lens to all our work, not just that delivered by Maori and Pacific providers.

In conclusion, health promotion will happen whether we structure it or not. There will always be ongoing planned and unplanned health promotion activities occurring across sectors and communities. However, if we want to maximize the potential health gains that coordinated and organised, well planned and collaborative health promotion interventions can achieve, then we as the sector must give priority to getting our own act together.

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