Strategies for Strengthening the Health Promotion Workforce
An Academic's Perspective

This discussion paper was prepared for the Ministry of Health as one of a series of 'Think Pieces' commissioned for the Public Health Workforce Development Plan. It has been prepared with informal consultation with a small number of academics and review of workforce research reports, Health Promotion Forum and Public Health Association competency projects.

While health promotion ideals and activities have a very long past, the emergence of a sizeable identified health promotion workforce has a relatively short history, probably only 2-3 decades at most in NZ. Its evolution from a predominantly health education, disease-prevention focus has been largely fuelled by the values and strategies of the WHO Ottawa Charter for Health Promotion (1986), and its subsequent WHO health promotion "charter" conferences, and a commitment to te Tiriti o Waitangi. Commitment to te Tiriti o Waitangi and the Ottawa Charter provides a unifying value base for this workforce, though, beyond that, diversity appears a major characteristic; diversity in work settings, in levels and types of education and training, in conceptual models and practices, in its relationship to working "with/on or from within" communities, and so on.

Comments in this paper are based on the following perceptions of the nature of the health promotion workforce.

1. The health promotion workforce goes well beyond the government work sector, e.g.,DHBs, PHO's, and includes workers in a wide range of other settings NGO's (e.g., NZ Heart Foundation, NZ Cancer Society, Age Concern), corporate sector (e.g., wellness/lifestyle agencies), local government (e.g., youth and community development initiatives) and a variety of Maori, Pasifika and other community-based initiatives. Thus the challenge for forming a notion of "the" health promotion workforce, its identity, its training, development and leadership needs.

2. The health promotion workforce is enormously diverse in terms of its members' entry-level experiences, qualifications, formal and informal training, levels and types of practice, career pathway opportunities, its focus on individuals, or groups, or organizations, or whole communities. Many in the workforce don't use the term health promotion as a job title; though clearly identify themselves as part of the health promotion movement.

3. Conceptually, the health promotion workforce works, explicitly or implicitly, across a range of perspectives, from a health development understanding of health and ways of working in communities (cf., People's Health Movement), through more community-mobilisation/action empowerment-focused approaches (cf., Ottawa Charter) through to models focused on disease risk factors and epidemiological, health-service driven arrangements for reducing disease at a community level. The discourses of "old" vs "new public health" and the relationship of health promotion to (or within) public health also cross-cut these perspectives. Thus, deciding what are core knowledge and competencies for the health promotion workforce is a significant challenge.

4. The logistics of project-driven funding, contracting processes and management perspectives often run counter to health promotion's widely expressed values of

consultation, intersectoral collaboration, and community participation. Thus, pragmatic accommodations around values and practice are often forced on the workforce.

1 How can access, cohesion and linkages in the development and delivery of Health Promotion training best be achieved?

Existing health promotion education opportunities include pre-university level qualifications for persons already in the work force e.g., Health Promotion Forum/MIT Certificate in Achievement in Introduction to Health Promotion and a variety of in-service workshop/seminar programs run by a mix of heath promotion agencies and educational providers.

At the undergraduate level, health promotion is offered in various stand-alone papers within Bachelors level degrees, e.g., nursing, occupational therapy, oral health, psychology, health sciences, sport and recreation and others. Otago University offers a Certificate in Health Promotion and Auckland University of Technology offers a BHSc with a major in health promotion and Certificate in Health Science and Diploma in Health Science with a focus in health promotion.

At post-graduate level there are also a variety of stand-alone papers that can be taken as parts of Masters degrees, e.g., in MPH, MHSc, similarly in some social and behavioural science degrees and with increasing interest shown from the marketing, communication areas.

Health promotion has no nationally accredited curriculum as applies in other health fields with formal registration requirements. Core knowledge and competency initiatives (Health Promotion Forum, 2002, 2004: Public Health Association, 2006) are available as guidelines.

Recommendations to enhance development and delivery of Health Promotion training.

1. Given the diversity of the current and foreseeable health promotion workforce it is clear that there needs to be multi-level, but layered and connected, education and training opportunities available. An agreed **national staircasing framework** with varied entry points and flexible transfer points is needed to support a coherent knowledge and practice base and also to provide incentives for the workforce to pursue education appropriate to their varying practice needs and ongoing career development.

2. Practice in the health promotion workforce ranges widely from grass-roots community level work, through program implementation in formal govt or non-govt agencies, through to senior level strategic planning, program development and management, training, research/evaluation and organisational management roles. An integrated education framework should factor these needs in at appropriate levels. Although, generic organisation, planning and management education are already available elsewhere, integrating these within health promotion education will provide a better fit for the health promotion understandings and management expertise required at these levels to lead the health promotion workforce. It would also open career options for senior health promotion

personnel to move into other health management positions where a health promotion perspective is often unfortunately lacking.

3. To develop a **national staircasing framework** would require, initially, active collaboration within the academic community to support such a framework, particularly around the logistics of the administrative "fit" between varying qualification requirements of the different institutions. The existing Academic Reference Group of the Health Promotion Forum could be the vehicle to take such a collaborative initiative.

4. It would be critical for full development of such a staircasing framework that there is strong linkage between the academic community and workforce representatives. The Health Promotion Academic Reference group could be extended to include workforce representation or that group could have close ties to a suitable workforce group.

5. At the local, individual education institution, level there should also be strong linkage between practitioner advisory groups and education programs to ensure practitioner input into curriculum development and particularly practicum placement and supervisory issues.

6. The possibility of joint academic/practitioner appointments should be considered as another way to ensure alignment between the education and workforce sectors. Such appointments are common in other health education areas.

7. Strengthening the research orientation and capacity of the workforce is important for effective development, management and delivery of health promotion activities. Much closer alliances between academic and practitioner communities should be pursued with a focus on research issues and questions of importance arising from the workforce and the communities they work in/with. A workforce model of "practice as research" and not something distinctly separate from research would help to promote robust research-informed practice. This would require integrating research education, at appropriate levels, right across the proposed workforce education framework. Within the academic and research funding agencies it would also require reconsideration of funding processes and priorities to ensure that there was funding support for more applied topics, community-driven issues, small-scale local studies, program development, implementation and dissemination studies, and so on.

2 How can strong and diverse leadership in Health Promotion be developed and promoted?

A strong and diverse leadership is essential for promoting health promotion priorities and perspectives at policy and planning levels and in the public arena, for efficient management and development of the health promotion workforce and the effective provision of health promotion services across the health and related sectors. Given the widely varying workforce and work settings, a range of strategies for strengthening leadership will be required. There are particular priority needs for leadership development in Maori, Pacific, refugee/new migrant health promotion and in primary health care.

It is important to clarify leadership **and** management needs within the workforce and the appropriate health-promotion based education required to support and enhance these knowledge and competency sets. Current health promotion education opportunities tend

to focus on health promotion values/principles, ways of working in/across communities, development and evaluation of health promotion initiatives, and so on, with relatively little emphasis on leadership and/or management within, or outside of, health promotion settings. Even though good leaders tend to self-select and rise to the top, health-promotion orientated leadership (and management) education opportunities would be valuable for enhancing this capacity and, encouraging emerging leaders. Strengthening this sector of the health promotion workforce would also provide an increasing pool of senior health promotion personnel able to move into influential management positions often held currently by persons with strong formal management qualifications but relatively little health promotion understanding.

Recommendations to develop strong and diverse health promotion leadership.

1. That organisations such as the Health Promotion Forum and Public Health Association (PHA) work collaboratively on workforce leadership/management development issues. In particular, they look to clarify strategic leadership/management needs within the workforce and to support the development and regular provision of specific health promotion leadership/management educational opportunities, drawn from existing workforce leadership expertise, and also from within the formal education sector via an academic grouping as suggested in 1.3.

2. That strategies for supporting and mentoring emerging leaders be developed within the workforce networking across health promotion providers.

3 How can a strong focus on community development for the Health Promotion workforce be maintained?

A strong sense of a "health promotion community" is important for sustaining a vibrant and effective Health Promotion workforce. Alliance building, sharing resources, collaborative planning, building networking capacity are all critical elements for building such a workforce community and for underpinning a community development approach to health promotion.

For some time, funding, management and contracting processes have tended to run counter to the tenents of cooperation, alliance-building and resource sharing required to strengthen a sense of workforce community. Research funding agencies also typically give lower priority to more process orientated small-scale projects, workforce development, and evaluation of networking strategies.

Recommendations to strengthen focus on community development in the health promotion workforce.

1. That issues supportive of community development in the workforce and community development approaches to practice be highlighted in the education initiatives outlined in relation to question 1 earlier in this paper.

2. That appropriate collaborative research opportunities be pursued by academic and practitioner communities. That research funding priorities be reviewed and challenged where necessary to ensure support for this important area of workforce development.

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

If we accept Health as a human right (access to conditions for good health), then, focusing on reducing social and associated health inequalities becomes a practice and ethical imperative. Education and workforce development opportunities must be imbued with this spirit to provide a workforce well-conversant with these ideals, their application and advocacy for them.

Recommendation for developing a focus on the determinants of health and reducing inequalities.

1**.** That a focus on the determinants of health and reducing social inequalities be considered priority content in the suggested national education framework as elaborated earlier in response to question 1.

5 How can the voice of Health Promotion within public health and primary health care be strengthened?

Health Promotion's underlying values and workforce diversity are unarguable strengths. However, they can also count against it and make it appear a disparate movement with identity and credibility problems, particularly with some who fund and/or manage health promotion initiatives. There needs to be greater knowledge about health promotion amongst decision-makers, funders, and those in management structures overseeing health promotion initiatives. This requires educational initiatives and requirements for education for those in key positions of influence and also for senior health promotion workers to consider such positions as possible career opportunities to bring health promotion perspectives to bear at these levels (referred to in comments on question 2).

6 How can competence in the workforce for Health Promotion be built and ensured?

The challenges to clarifying what constitutes "the" health promotion workforce and its core knowledge and competencies were presented at the outset of this paper. Given its diversity, building enduring competence will require a range of strategies that encapsulate its unifying values and principles, but, with a variety of capacity building options that reflect the range of needs of those seeking education and competency enhancement. The Heath Promotion Forum's core competency guidelines and Public Health Association's generic public health competency guidelines are foundations for this. Though, where health promotion sits within, or, ***in relation to***, mainstream public health is a critical issue to be worked through in determining what constitutes core knowledge and practice.

Recommendations for building and enhancing workforce competence.

1. Developing an integrated staircasing education framework is a priority. This requires fruitful alliance across the workforce, its representative bodies, and the academic sector and is referred to in more detail under recommendations for question 1.

2. The challenge to determining core educational content and practice should not be underestimated given the varied and sometimes conflicting discourses that underpin practices (cf. point 3, p1). There needs to be clear recognition that the workforce cross cuts the formal health sector, other govt sectors and a wide range of NGOs, local government and other community settings and will require a robust credible core but with strands reflecting its varied perspectives and practice needs.

7 How can cultural competence in the workforce for Health Promotion be built and ensured?

A culturally aware and competent workforce is critical to achieving health promotion's objectives. Te Tiriti o Waitangi, as founding document of state, lays out the obligations and expectations of the relationship between the Crown and Maori. Within health promotion this translates to "meaningful Māori participation at all levels of health promotion including decision-making, prioritizing, purchasing, planning policy, implementing and evaluating health promotion services . . .It is about creating and resourcing opportunities for Māori to exercise tino rangatiratanga, control, authority and responsibility over Māori health (Health Promotion Forum, 2002)." This demands of the health promotion workforce understanding and commitment to te Tiriti o Waitangi to honour the special relationship between Maori and the Crown and to focus on reduction of social and associated health inequalities and the inadvertent production of further inequalities through health promotion activities.

Aoteoroa's increasingly diverse population creates demands for workforces knowledgeable about te Tiriti's obligations on the Crown in relation to Maori and also how te Tiriti and the Ottawa Charter relate as the basis for health promotion activities in Aoteoroa generally e.g., with Pacific Island, burgeoning new migrant/refugee communities and others. In addition, working with Pacific communities requires an understanding of the special relationship that the Government has with Pacific people…..a need to protect and foster Pacific cultures and identities, and……..to recognise that Pacific people should have the same socio-economic opportunities as non-Pacific people." (Ministry of Justice, 2000). Recent translations of te Tiriti o Waitangi into chinese and korean at AUT University should become valuable resources in curriculum planning for health promotion workforces in those communities.

Recommendations to build and ensure cultural competence in the workforce.

1. That within core competency and national educational staircasing initiatives that the increasing cultural diversity of our population is actively recognized. That te Tiriti o Waitangi be recognized as paramount as the basis for relationships between the Crown and Maori, that te Tiriti and the Ottawa Charter form the platform for health promotion activities within Aoteoroa, and that different ways of working and differing needs within and across communities are actively reflected in education and training initiatives.

2. That support e.g., scholarships, training schemes, be available to enhance Maori, Pacific Island and workforces for working in refugee/new migrant communities. That this support be focused on enhancing practice and research skills to better work with, and understand, the needs of those communities.

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